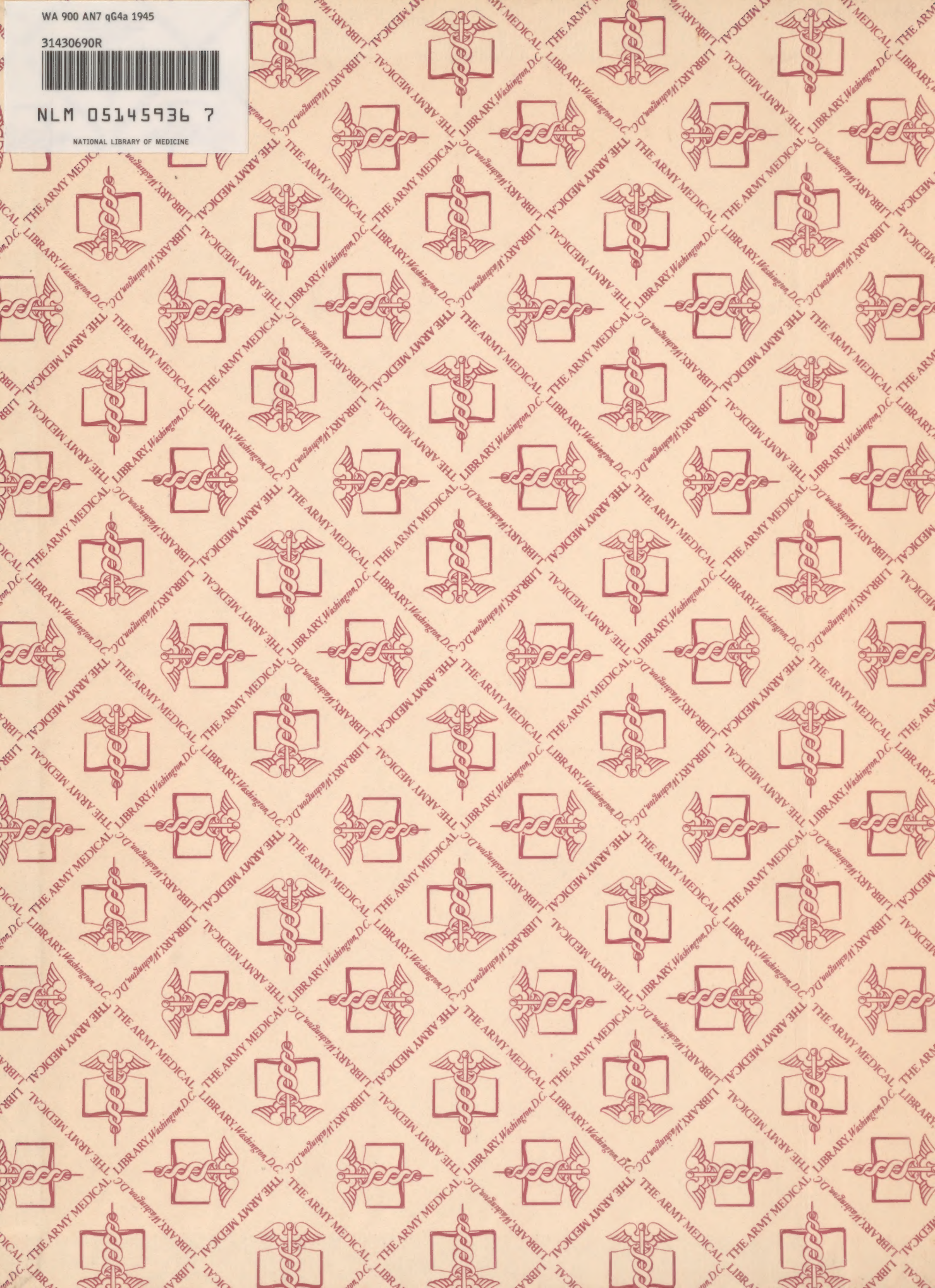

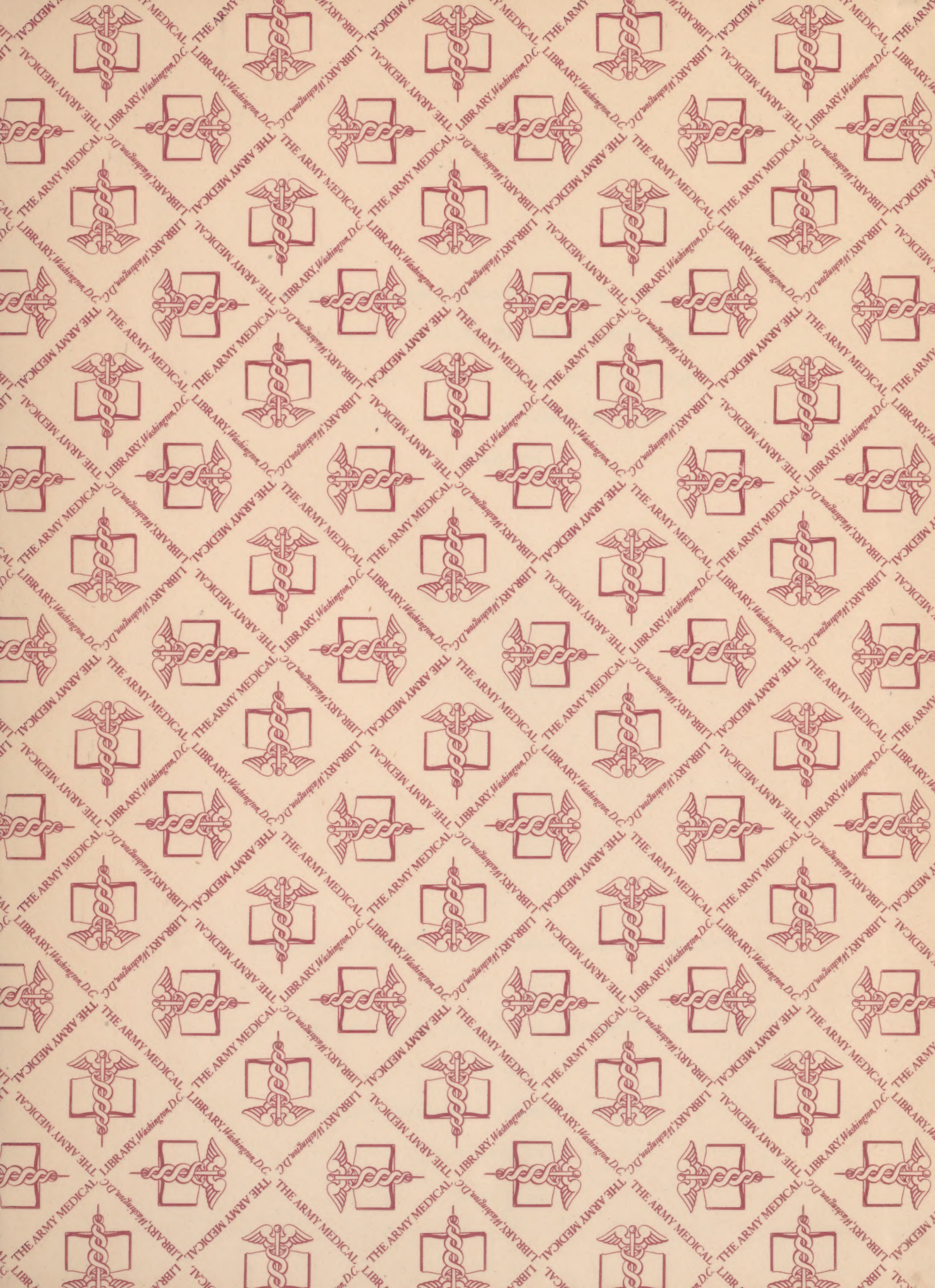
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The Attitudes, Opinions, and Actions of Certain Yorkville Families Regarding Health and Illness Together With Their Knowledge and Use of Local Health Resources,

A Pilot Study

by

Paul B. Gillen

under the auspices of

The Kips Bay-Yorkville District Health Committee

and the

Department of Public Health and Preventive Medicine

of the

Cornell University Medical College

New York City

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Acknowledgements

Adventuring into uncharted fields is seldom the privilege of many. Such has been the privilege of the writer in the field of public and personal health. While there is abundant empirical evidence for the more obvious tenets held in the field of family health, and while there are also to be found here and there organizational reports on some aspects of family health, one finds little or no comprehensive research upon positive health of families or their failure to seek it. To be sure, there are many reports upon vital statistics of our people, upon acute and chronic diseases, but basic work in the fields of attitudes, opinions, habits, and criteria for action especially concerning the health of the low income family is almost nonexistent.

This report is but what is hoped will be the beginning of the search for the keys that will help to unlock the familial and community barriers to sound health. It is in essence a pilot study, based upon techniques and assumptions that are different and untried. Necessarily it involves research procedures, case study, and statistical application. To the uninitiated or the indifferent, such tools seem to be of little value - yet it has been by the patient and persevering application of them that most if not all of our basic discoveries in the natural and social science fields have been made.

The Kips Bay-Yorkville District Health Committee has a philosophy and a perspective that is not only unique but is also definitely challenging. While it is very interested in reaching people, the members have through experience and long observation of the health of people come to seek an approach that is neither doctrinaire nor invalid. It therefore seeks not to launch upon a program using the time honored approaches, but rather through study of the people to find those channels of communication and those methods of dealing with people that will be most effective. The critic will say that in the meantime people are in need of information

and perhaps help. One does not need to go far afield to point out that there are and have been hundreds of families who do need help and who would act upon advice, but who under the present approaches go without suitable advice.

Dr. Wilson G. Smillie, Professor of Public Health and Preventive Medicine of Cornell University Medical College has been continually helpful and greatly interested in the suggestions of the District Health Committee. Convinced as he is that only through a thorough knowledge of the people can effective changes in health practices be obtained and that there is more to total health than the clinical side of medical practice, he has lent moral and financial support to the pilot study. Through his interest, it was possible to employ Miss Gladys Swackhamer as the field worker for the project.

The writer wishes to express his deep gratitude to the chairman of the committee, Mrs. William S. Ladd, for her untiring efforts in the interest of the people and for her challenging viewpoints. He is likewise indebted to Mr. Lawrence K. Frank of the Institute of Human Development for his searching analyses of the needs of the people and for his stimulating criticisms.

Last, but not least, the writer wishes to make special mention of his indebtedness to others: Dr. Hadley Cantril, Director of the Office of Public Opinion Research of Princeton University; Dr. Neva Deardorff, Director of Research for the Welfare Council of New York City; Professors Wilbur C. Hallenbeck and Edmund deS. Brunner of Teachers College, Columbia University; Dr. Herbert C. Edwards, Director of the Bureau of Tuberculosis, Health Department of New York City; Miss Elise de la Fontaine, Director of the Yorkville Office of the Community Service Society; Miss Caroline Falls and Miss Alda Dauch of the Lenox Hill Nursing Service of Community Service Society; Miss Olga Carlson, Supervisor of the Kips Bay-Yorkville Branch of the Visiting Nurse Service of New York City; Miss Theodate Soule, Director of Social Service of the New York Hospital; Miss Louise Keiber, Supervisor of Public Health Nurses, Kips Bay-Yorkville District Health Center; Dr. Myron E. Wegman, Director of Research and

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Special thanks are due to Mrs. Sara Frenkel who gave untiring assistance in tabulation and other clerical work.

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Introduction

This survey was conducted for the purpose of checking upon the validity of assumptions regarding a new approach to the consideration of problems of ill health among low income people. It is neither an intensive nor a comprehensive study, but only the forerunner of a proposed study to involve more people and more aspects of family illness. It represents a beginning effort and as such is a part of the philosophy and objectives of the major effort.

People living in New York are confronted with many perplexities and often acute problems of personal living for which their traditional ideas and patterns are no longer adequate. They have not yet accepted or been able to utilize the new resources available for their help. It seems evident new patterns of procedures should be used to aid families in the translation of knowledges and skills into terms that have meaningfulness and that coordinate with their other beliefs and practices.

Before giving the reader some idea of the philosophy and objectives of the major effort, a thumbnail sketch of the people and their environment is presented. Ninety five families were interviewed by the use of a comprehensive questionnaire, a copy of which may be seen in the appendix, together with a statement of the plan of the study. These ninety five families comprised 309 individuals, who by criteria for normal times would be in the low income brackets. They live in "railroad" type apartments in five story walkups. The houses are at least forty years of age and were built under conditions when housing was in great demand. The area in which they live is called Yorkville and is located in the middle east side of New York City.

The people represent first, second, and third generation Americans and also some non-naturalized Europeans. For the most part, they are of Czech and Slovak extraction, although quite a few nationalities other than Americans are present. Part III deals in some detail with demographic and ethnic factors.

Here and there throughout the report, the phrase - "Social Block" appears. By this is meant two sides of the same street. This study reports upon families who for the most part live on one side of a street only a short distance from the Kips Bay-Yorkville District Health Center of the Health Department of the City of New York. The selection of a social block as a working unit was based upon several assumptions: (1) no one knows very much about the health and related problems of such a block of people, and (2) even though urban isolation and desire for anonymity are present, channels of communication among the people exist to a much greater degree in such a block than would be the case in any other unit that might be chosen.

The major study is proposed for the purpose of exploring the problems impinging upon adequate health in the population living within a social block in New York City. People have lived in urban areas under a remedial type of welfare philosophy, the application of which has resulted in many interesting and diverse patterns of procedures, especially the methods and techniques developed with the avowed purpose of building public and personal health. Facilities made available have been considered adequate in terms of past experience, one of the criteria for which has been the application for help by the people. Enough evidence is at hand to suggest that many families, while needing information and professional aid have not taken advantage of opportunities easily within their geographical and economic reach.

Traditions and beliefs play an important part, and it is probable that our present pattern of practices does indeed arouse resistance to our efforts toward the promotion of good health and wholesome living. For example, little is known about the health values and beliefs held by the family units within the different nationality groups, with particular reference to disparity between standards, knowledge, understanding and practices. Moreover, it would be valuable to know the nature of the selectivity factors by which people make use of or reject available resources,

If we could gain some further light upon the question of family health practices, beliefs, and leadership, we should be in a position to adjust our thinking and services to actual needs, thus hoping to improve existing health services. Where health programs continue to be a mixture of laissez-faire attitudes on the part of agencies, there results a pattern of thinking and action which implies the need for an educational procedure that will break through the barriers of prejudice, lack of information, and antipathy toward public health services. In order to throw some light on these problems, a typical social block of the population is to be selected to make an intensive study of the actual health of the people, beginning with a service and continuing with the education of the family.

Purpose of Study

Survey

1. To tabulate the actual acute and chronic diseases in the block at the time of the interview.

2. To discover leads for improving the health services for each member of the family.

Exploration

1. To discover techniques for reaching these people who need health information and services, but who have not availed themselves of the existing resources.

2. To discover the natural channels of communication for health among the people.

Goals

These purposes will be achieved to a large extent in terms of a continuing rapport with the people in question, through which we hope to keep an up-to-date inventory of health, and find an understanding of what people mean by "good health", and of the ways in which they seek to attain it.

The sections that follow present the results of the questionnaire (see appendix) and attempt to interpret the data reported. It should be borne in mind that the number of cases is not large and that the whole report represents a pilot study. In the major research, the schedule mentioned here together with others to be developed would be applied over a period of several years.

The Plan of the Survey

This project considers both sides of the same street as a "social block" and as a basis for evaluating the needs of the people. We do not know just what may be the nature or degree of communication among the members of such a block, but we are convinced, on an empirical basis, that much more can be discovered about neighborly communicating than would be the case if we used a geographical block basis. Part of the work in the future will involve an attempt to discover the kind and degree of communication that occurs in a social block. Furthermore, no one knows with respect to New York City, because of fragmentation of services, what happens to the health of the people in a contiguous living situation. Where services are largely on the basis of invitation by those having recognized health problems, there are numerous reasons for forming the rule-of-thumb conclusion that need is present which is unmet.

It has been estimated that as many as three hundred or more families live in a social block. The results reported in this paper have been obtained by test interviewing ninety five families, most of whom live on one side of the block of a street not far from the municipal district health center. The main purpose in obtaining the interviews was to try out the questionnaire and procedure and thus gain experience for conducting the major study. A copy of the questionnaire may be seen in the appendix - next exhibit.

Since the study-demonstration is to apply to ethnic groups of low income living under tenement conditions in New York City, it was necessary to apply the sample interviewing to a block of people as similar as possible to the block to be studies in the major attempt. The two blocks in question were selected on the following bases:

1. Low income as reflected by rents paid
2. Variety of ethnic representation
3. Degree of overcrowding
4. Size of population

5. Uniformity of living quarters

6. Fairly low incidence of number of buildings for non-living purposes

7. Nearness to Health Center

8. Empirical evidence

9. Suggestions made by social workers and nurses

Wherever possible, all the families in a specific tenement building were approached. This seemed desirable so that the ecological factors involved would be as closely related as possible. Furthermore, since some of the questions involved the possible use on the part of the respondents of neighbors and friends present in the same building or closely adjoining buildings, it was necessary to exhaust all the possibilities present in each building for information. As indicated elsewhere, the sociometry of the social relationships should be the subject of further intensive study as the sponsors are convinced that therein lies part of the answer to the whole problem of communication among the people. It is very likely true that they have communication webs for each of the major problem areas in life such as food, clothing, shelter, education, health, and so on. These webs are probably distinct patterns in their own right, but it is also likely true that there is considerable overlapping as respects the membership of the webs. This problem was attacked on the basis of "friendship circles" in a nutrition study-project by Koos.[3] That study revealed some interesting leads for the make up of natural groups and for the power of persuasion shown by group leaders.

The questionnaire was devised partly with the idea of building improved rapport between the families and the Health Center. This idea took the form of asking the respondents the kinds of things they would like to read and then telling them that we would put them on our mailing list. Packets of materials were sent to the homes several weeks after the interview. It would be wise to send other materials

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[3] Koos, Earl L. - Food in the Lives of Our Neighbors, District Health Committee, Kips Bay-Yorkville Health District, New York City, 1942

at regular intervals.

The problem of the opening of the interview was given considerable attention. It was finally decided to stress the shortage of doctors and nurses due to the war situation and to inquire if the families were having any difficulty in getting adequate service within a reasonable time. This approach seemed to work very well, particularly when coupled with the inquiry as to whether the family had received a letter telling of the survey. There were no "door-sill interviews". The interviewer, in all but three instances, was asked to sit down in the apartments and was treated with courtesy and frequent cordiality.

The length of the questionnaire seemed to be a source of concern to several members of the staff, but experience proved that "the too busy housewife" was not too busy to give time to answer the questions and to be friendly. On the average, the interview took forty minutes to complete. In test interviews by the director and also by the interviewer, the question was put to the respondent regarding the length of the interview and no objections, overt or implicit, seemed to be forthcoming.

PART I

The Health of the People During the Past Year

That attack upon the problem of ascertaining the incidence of illness among the people during the past year was of a three fold nature:

1. An inventory of the present health problems (with and without professional attention)
2. Hospitalization during the past year
3. Disabling illness during the past year involving complete care at home (non-hospitalization)

Wherever possible, an attempt was made to try to get at any blockages which would inhibit or prevent resort to adequate care. For example, guarded questions both direct and indirect, involving the means test were applied. It was found necessary at times to help the respondents to recall their family health problems as some of the family representatives were at first confused as to the motivating factors behind the survey.

Care was taken to elicit information which would permit some differentiation between acute and chronic illnesses. Duration was used as the chief criterion and revealed that most present health conditions are chronic. Complete reliance cannot be placed upon all answers for reasons of misinformation, misunderstanding, language difficulties and poor memory. On the whole, the information was given spontaneously. It is perhaps likely that were all medical records checked and the respondents interviewed again, considerably more information as to extensity and accuracy would be available. However, sufficient data was obtained to enable the investigator to discern a rough measure of kinds and incidences of health problems.

Present Illness

Cataloging the illness of a group of people when the descriptive terms come from the people themselves rather than from a member of the medical profession generally presents some difficulties. The problem is not so difficult as far as the

ordinary well known diseases are concerned.

In answer to the question - "Does anyone in your family have something wrong with him now?", 78 of the families replied in the affirmative, while 17 reported negatively. Very careful attention was given to seeing that the respondents understood the question and that they realized it applied to health. Their understanding and acceptance of "something wrong" is colored to some extent by degree of disablement, by economic involvements, and by the fact that among people of low incomes ambulation may be taken as a pretty good test of health. Putting it another way, people are often so involved in making a living and getting along that they do not have time to be introspective or of a hypochondriac nature - consequently they are likely to ignore what appear to be minor disabilities or those that do not interfere with their usual patterns of living.

The 78 families reported that 128 individuals needed some kind of medical attention (including major dentistry). The following tables, 1 and 2, show the family members involved and the age distribution of persons having health problems.

Table 1

FAMILY MEMBERS WHO HAVE SOME NEED AT PRESENT FOR MEDICAL ATTENTION[1]

Family Member	Number
Husband	31
Wife	47
Daughter	17
Son	15
Relative	5
Other	13
Total	128

[1]Including major dentistry

Table 2

DISTRIBUTION OF PRESENT PHYSICAL MALADJUSTMENTS BY AGE AND BY SEX[1]

Age	Number of Individuals Male	Female
1-5	1	2
6-10	6	4
11-15	3	2
16-20	2	5
21-25	2	6
26-30	4	2
31-35	2	5
36-40	4	10
41-45	1	3
46-50	8	14
51-55	2	8
56-60	8	4
61-65	3	4
66-70	1	3
71-75	4	3
76 up		2
Totals	51	77

[1]Including major dentistry

Since there are 309 individuals in the 95 families, it is to be noted that 41.4 percent of the group have some health problems including dental needs. And it may be safely assumed that these people do consider them as problems. For example, a few dental caries mean little to them. When they speak of the need for dental attention it usually means a condition of an extensively serious nature. The fact that 77 women as against 51 men were in need of medical attention is significant and calls for further investigation. It may be that the female partner of the marital contract often (and particularly in the low income family) permits herself to procrastinate in giving adequate attention to her own health.

In the 78 family units admitting some health difficulty, 32 members are being attended by private physicians, 16 by some department of a local hospital (mostly out-patient), and 1 by a Department of Health Clinic. Only 49 persons of the total 128 needing attention are getting it. If we allow for the 29 needing dental attention, the number needing medical care is 101, although some of the 29 persons had other health problems. Responses suggest as deterrents in seeking medical care: fear, economic pressures, attitudes toward publicly supported services, confusion and ignorance as to how to go about getting adequate attention with a minimum loss of time from work or the responsibilities of maintaining the home, ethnic background prejudices against the use of medical resources only in cases of severe illness, and the like.

Often the question is raised as to the approximate size of the health problem in a given block of people. For several reasons, including the varying definitions given for morbidity, such a question is difficult to answer. Consequently, the following information is given in terms of the kinds of things that people would choose to include in reply to the question about someone in the family "having something wrong with him". Trifling things of an inconsequential nature were not mentioned by many of the respondents. The table on the following page tells the story of the current and continuing health problems found in the 95 families at the time of the interview.

Table 3

INVENTORY OF THE HEALTH DISORDERS OF THE 95 FAMILIES AT THE TIME OF INTERVIEW (JUNE, 1944)

Disorders (Classified according to National Institute of Health 1943 Code)	No. of Cases
Infectious and Parasitic	
Encephalitis	1
Rheumatic Fever, Diseases of the Endocrine Glands, Nutrition, and Other General Diseases	
Nutritional	17
Diabetes Mellitus	2
Rheumatic Fever	1
Blood and Blood Forming Organs	
Anemia	1
Chronic Poisoning and Intoxication	
Chronic Poisoning	1
Intoxication	1
Nervous System and Sense Organs including Mental Disorders	
Eyes	8
Ear and Mastoid Process	2
Circulatory System	
Hypertensive Vascular Disease	10
Varicose Veins and Hemorrhoids	7
Diseases of the Heart	5
Low Blood Pressure	1
Arteriosclerosis	1
Respiratory System	
Asthma and Hay Fever	3
Bronchitis	1
Pharynx and Larynx	2
Pneumonia	2
Other	4
Digestive System	
Buccal Cavity	29
Appendicitis	2
Diarrhea and Enteritis	1
Functional	4
Hernia	2
Liver and Gall Bladder	3
Stomach and Intestines	2
Ulcer of Stomach and Intestines	2

continued on next page

Table 3 (continued)

Disorders	No. of Cases
Deliveries and Complications of Pregnancy	
Delivery	1
Pregnancy	1
Genito-Urinary System	
Female Genital Organs	4
Kidney	1
Skin	
Acne	2
Allergy	1
Bones and Organs of Movement	
Arthritis	9
Other	3
Congenital Malformations	
One lower extremity shorter than the other	1
Injuries	
Fractures	2
Total	142

It is sometimes said that many people have health problems of which they are unaware, some of which terminate in sudden death; while others are perfectly aware that something is wrong but choose for various reasons to do nothing and hence continue along in life to the best of their ability. While it is true that the group of people financially able to pay for medical attention frequently postpone seeking it, on the other hand, the low income family puts off securing medical attention largely, but not solely, for economic reasons. This fact is brought out by several of the questions, the results of which appear below.

Table 4

WHAT PEOPLE SAY THEY WOULD DO TO HELP IMPROVE FAMILY HEALTH IF MORE MONEY WERE AVAILABLE

Get Dental Care	Have Mal-Health Condition Diagnosed and/or Corrected (go to a doctor or hospital)	Go for More Treatment (continue treatment)	Move to Country	Vacation in Country	Better Housing	Total
18	11	3	7	7	3	49

Undoubtedly there is a much greater incidence of need for dental care than is revealed here. Inasmuch as many of the people come from ethnic backgrounds in which care of the teeth is a luxury and there were few dentists in the countries of their birth, it is not surprising that inadequate attention is paid to degenerated oral conditions. In fact, it is well known that some families with a higher weekly income neglect to get proper and timely dental care.

As indicated, 11 of the respondents knew of some family health problems which needed serious medical attention and 3 others would like the advantage of further treatment. It is probable that others knew of chronic conditions in their families, but for various reasons felt futile about expressing a desire to do something about the situation. The complaints were largely of a chronic nature. It was especially noted that some of the families were quite aware that health has a broad interpretation and that environment plays an important part. 17 of them indicated some need for improving the conditions under which they live, either in temporary or permanent manner.

Hospitalization During the Past Year

This part of the report catalogs illnesses that were hospitalized during the past year (concluded by June 1944). The criterion for hospitalization was "over night or longer". No attempt was made to study the number of days involved, the details of kind of service rendered, nor the costs. See Table 5.

Table 5

NUMBER OF PERSONS HOSPITALIZED WITHIN PAST YEAR
AS REPORTED BY MEMBERS OF 95 HOUSEHOLD UNITS[1]

Hospital Used	Husband	Wife	Child	Other Relatives	Total
City		1			1
Joint Diseases			1		1
Lenox Hill	2	1	2		5
Manhattan Eye, Ear, and Throat			1		1
Metropolitan	1	2			3
Midtown			2		2
Misericordia		1			1
New York	1	4	6	1	12
Post-Graduate	2				2
Roosevelt			2		2
St. Clare			1		1
York			1		1
Totals	6	9	16	1	32

[1]One child went to two hospitals for same condition
One wife went to two hospitals for three different problems
"Hospitalization" means a stay of over night or longer

The significance of proximity in the lives of these people is again to be noted. Not quite half of the cases requiring hospitalization were treated in New York Hospital. Some of the reasons why hospitals are popular may be seen by referring to Table 6 (see following page). In the main, people were generally well satisfied with their hospital experience. In a few instances, some criticisms were given, such

Table 6

THE REASONS PEOPLE GIVE FOR THEIR CHOICE OF HOSPITALS

Reasons for Preference	HOSPITALS														Total
	A	B	C	D	E	F	G	H	I	J	K	L	M	N	
Best doctors	1								2			1			4
Cleanliness									4						4
Equipment									3						3
Family doctor on staff								2							2
Good attention		2	1			2			15						20
Good food									2						2
Good visiting hours								1							1
Local opinion quite favorable						1			2						3
Low cost								1							1
More modern									1						1
Nice nurses						1			2						3
No knowledge of other hospitals									2						2
Previous experience (unqualified)		1	1	1	1	5			6	1	1	3	1	1	22
Proximity to home									12						12
Worked there						1			1						2
Totals	1	3	2	1	1	10		4	52	1	1	4	1	1	82

as: "failure to make proper diagnosis", "failure to use proper care (surgical), and, "too many insects around". The criticisms were so few in number that they may be ignored. As an attempt to get a check upon veracity and/or memory, the records of one local medical resource were checked to see what degree of accuracy existed between what the doctors said and what the people understood them to say. In 61 cases there was a close agreement, but in 54 cases there was definite disagreement.

Disability Illness Cared for at Home During the Past Year

During the year in question there were some among the respondents who were confined to their homes for varying periods of time. To attain uniform reporting, the criterion used was one week. This was done to rule out minor difficulties and to aid the respondent in recalling the more serious situations. It is true that even though a person may be confined to his bed for a week his illness may not necessarily be serious. However, in the case of these families, when someone sees fit to go to bed for as long as a week, it is usually true that he feels really ill. 53 of the families reported that someone had been ill in bed for a week during the year, making a total of 65 individuals. The following table signifies the family member affected and the kind of aid that was solicited as described by the respondents.

Table 7

INCIDENCE OF ILLNESS AT HOME DURING THE PAST YEAR BY FAMILY MEMBER AND BY SOURCE OF AID

	Parent	Relative	Neighbor	Doctor	Other	Total
Father				6		6
Mother		11	5	9	6	31
Child	10		1	15	2	28
Total	10	11	6	30	8	65

N.B. Some family members had more than one source of aid

The importance of the maladjustments may be noted by the number of families who called in a doctor. There were some persons, notably wives, who in all probability needed a doctor, but for reasons already discussed, did not see fit to call one. It would be plausible to conclude that the men enjoyed better health than the other members of the family, but this would be fallacious on several counts; e.g. since the father is often the major breadwinner he cannot afford time off, and he frequently gets the "breaks" in the way of food, clothing, medication and attention; second, he gets many more opportunities for changes of environment than the mothers enjoy; i.e., in work, and in leisure which some of the fathers spend in the Sokols, the corner taverns, or elsewhere; third, if there is really any relation between housing and poor health, again it would be the women and children who would be the victims. See Table 8 on the following page.

Again, because of the small number of cases, one cannot generalize, but at least one may observe that the highest incidence of respiratory disease was found among the mothers at the time of the survey. Perhaps lack of adequate clothing, of adequate heat, and of adequate sun and overcrowding were among the predisposing factors.

Some of the families were in the midst of social crises due to the illness of one or more members, yet none of the families reported that anyone other than a school nurse came to see some of them. She generally came on routine matters. Not a single family reported any counselling on the social and/or economic problems associated with illness. Yet it was obvious to the investigator that such a service was needed. Since this is only a pilot study, no effort was made to ascertain the kind of help which some of these families undoubtedly received from various agencies over the years. A follow-up on this point should prove of value.

It is recognized that the foregoing presentation is very inconclusive and perhaps unsatisfactory from a medical point of view. One of the areas that would likely show up, if it were possible to do a series of interviews is the need for mental hygiene. It is hoped that an opportunity will present itself whereby some measure of the need for mental hygiene may be gained.

Table 8

ILLNESS AT HOME DURING ONE YEAR[1]
INVOLVING ONE WEEK CONFINEMENT

Illness	Father	Mother	Child	Total
Infectious and Parasitic Diseases				
German Measles			2	2
Glandular Fever			1	1
Measles			4	4
Chicken Pox			3	3
Scarlet Fever			1	1
Circulatory System				
Hypertensive Vascular Disease		2		2
Respiratory System				
Influenza		10	4	14
Cold		4	3	7
Tonsillectomy			1	1
Tonsillitis			1	1
Bronchitis		2		2
Pleurisy	1	1		2
Pneumonia	1	1		2
Digestive System				
Appendicitis			1	1
Buccal Cavity	1			1
Functional		2		2
Jaundice	1			1
Ill-Defined Diseases				
Abdominal pain		1		1
Fever			1	1
Other[2]	2	2	1	5
Totals	6	25	23	54

[1]Based on National Institute of Health Code (1943). Incidence based on cases

[2]Includes one eye infection, one mastoid process, one kidney infection, and one delivery

The foregoing story of illness in a very limited way, sets a kind of pattern for other blocks of people of the same major ethnic groups having comparable characteristics. The writer, in his work among the groups in question, sought to find concurrent with the survey, an explanation of apparent resistance to information about health. The situation is symbolized by the remarks of one leader:

> "I wish our people would see that they do need more information about their health. They are too satisfied with old ways of doing things and as a result they unconsciously permit a pattern of living to continue that they could easily change. They are bull-headed about it. I intend to be of assistance wherever and whenever possible to change these attitudes."

The subsequent parts of this report show the degree to which this kind of blockage exists. The foremost implication is the need for modifying our present pattern of health information. Relatively few people listen even intermittently to radio health talks or go to health lectures. The mass broadcasting of health information should by all means be continued in as many novel and dramatic ways as ingenuity will permit. However, considerable study should be given to attempts at evaluation. Moreover, it may be well to consider the development of methods that would reach those families who seem to be immune to mass methods of distributing information.

PART II

The Kind of Aid the People Seek in Times of Illness

The psychology of the family during times of emergency involving illness is often a complex phenomenon and frequently cuts across economic and social class lines. This part deals with what the ninety five families did or said they would do when and if illness arose in the family. It must be borne in mind that the interview presented questions somewhat hypothetical in nature and that consequently, the answers given cannot be completely relied upon. There is the lurking suspicion that some of the respondents did not fully grasp the significance of some of the questions. Moreover, the answers may have been colored in terms of what the respondent might do today, whereas what he would do tomorrow might be entirely different. Of course, the answer to the questions may have been in the nature of an aided recall, i.e., the most recent family situation; it may have been an answer closely connected with some emotional disturbance in the family; or it may have been an answer in terms of degree and kind of illness. No attempt was made to check upon these factors as the schedule would have been unduly lengthened and the respondent might not have answered whole heartedly the remaining questions. Here again lies a fruitful field for further investigation.

Criteria the Families Used for Making a Decision to Seek Professional Help

Serious illness in the family presents the need for thought and action. In an effort to learn the criteria by which the family determined the need for professional attention, the family spokesmen were asked how they knew when a person is sick enough to require medical services. Some knowing smiles accompanied the replies as well as some subtle expressions of mild amazement that such a question should be asked of them. However, all respondents answered the question as evidenced by Table 9 on the next page.

Table 9

THE SYMPTOMATIC CRITERIA BY WHICH FAMILIES DECIDE THE NEED FOR CALLING A DOCTOR OR FOR HOSPITALIZATION IN CASES OF SERIOUS ILLNESS

Symptomatic Criteria	No. of Cases
Acute pain	13
Coloration	7
Decided loss of interest or activity	5
Feeling state	16
Loss of appetite	6
"Obvious"	2
Temperature rise	56
Vomiting	5
All others	27
Totals	137

While certain symptomatic conditions were frequently named, it is to be noted that seldom did a respondent limit his reply to one symptom. The most frequent pattern was that of temperature, feeling state, and pain.

Seeking Professional Help in Times of Illness

Some people seem never to know what to do about an illness, whether the onset is sudden or whether the more obvious symptoms have been in evidence for sometime. In some quarters the supposition has been that low income folks, particularly those in strong ethnic groups, do considerable fumbling when serious sickness arises. The survey shows that even though there are some who cannot afford a private family physician and others who shun publicly supported health resources, yet when someone in the family falls seriously ill, a doctor is usually called. 66 respondents, or 69%, showed no hesitation about what they would do - they would call a doctor. 11 would call an ambulance, (municipal), and 13 would take the sick person to a hospital. However, the last group of respondents did not volunteer information about how they would go about getting the person to a hospital.

The Family Doctors

The question of the kind of help people seek has been partially discussed already. It will be recalled that many said they would go for a doctor. Further exploration in this area regarding the doctor is revealed that 49 of the families have their own doctor and 45 do not. They call the family doctor most of the time when someone is ill, but they do not, on the whole, know too much about their doctors. For example, 49 claim to have a family doctor, but only 24 knew the kind of practice their doctors had. 22 thought their doctors to be general practitioners while two families knew their doctors to be specialists. The latter point raises the question as to whether the people really know what a family doctor is. In all, 24 doctors were identified as serving 49 families and in most instances, the offices of the doctors were within walking distances of the homes of the patients. The number of doctors included is somewhat surprising.

After the survey was under way, it was decided in the last 45 interviews to try to ascertain the reasons people might give for their choice of doctors and also the date of the family doctor's last visit with a member of the household. Most of the respondents who answered the first question said that they learned of their doctors (and his competence) through people they knew - relatives, friends, neighbors and acquaintances. In some instances one doctor would recommend another. It is interesting to note that in only one instance did some organization name a doctor - that was a beneficial society. Nearly all those interviewed thought highly of the doctor of their choice.

Another question, of when someone had gone to the doctor's office or he had come to the home, was put to the last 45 of the respondents. Only 24 family representatives recalled seeking private professional care. The table below reveals the recency of the use of such care.

Table 10

VISITS TO OR BY PRIVATE DOCTORS

Recency	No. of Individuals
Within last month	7
2 - 4 months ago	4
5 - 12 months ago	5
1 - 2 years ago	7
3 - 4 years ago	1
	Total 24

It will be noted that only 16 of these 24 respondents claimed having used private medical care during the past year for their families. A check upon these 16 further reveals that such service was used in the main for the women and children. Some of the illnesses were acute, but the majority were chronic. Furthermore, 12 of the families seemed to use private medical care for some conditions and clinic services for other conditions. Here is an interesting pattern involving the use of the clinics on some occasions and private medical care on other occasions. An interesting theme for further investigation would be a study of what the motivating selectivity factors might have been. One would be prone to assume that private doctors were called, in the main, not because of the nature of the disorder, but probably because of the possible feeling that clinics are good for some health problems, but not for others. These are queries only and should be regarded as such until future research reveals the real facts of the matter.

Choice of Hospitals

Some of the families seem to have unique criteria for making a decision for hospitalization of a family member. It will be undoubtedly objected that the question of deciding to seek hospitalization independent of professional advice is too technical and also too subjective for an intelligent answer yet the fact of the matter is that these people do face such situations and do have to make decisions. A significant number of them rely upon their own judgments; consequently, the asking

of such a question is necessary, if we are to have some insight into the health and illness pattern of the low income family.

Where to take the sick person is always a challenging issue for the family. Of course, the obvious answer is to some hospital they have used or know about. When confronted with an illness requiring or seeming to require hospitalization, many of the families in the survey knew their choice of hospital. See Table 11.

Table 11

QUALIFIED AND UNQUALIFIED CHOICE OF HOSPITALS IN EMERGENCIES

Qualified Choice of Hospital in Emergencies

New York	Lenox Hill	Presby-terian	City	Miseri-cordia	Gotham	Fifth Avenue	Post-Graduate	Catholic Hospital
41	6	2	3	1	1	1	1	1

Unqualified Choice of Hospital in Emergencies

Nearest	Where Doctor Sends	Anywhere	No Choice	Don't Know
19	3	4	2	2

The data shows a marked preference for the New York Hospital which is the nearest one to the people living in the block. Eight other institutions are mentioned. Among the unqualified choices, the "nearest" hospital is mentioned which again would mean the New York Hospital. There is a qualification inherent in the statement of the respondents which means that a number of them believe that all hospitals are equally to be preferred.

The people have evidently had experience with the hospital emergency clinics and appear to know about them and something of the kinds of services that are offered. However, it is not known for certain whether the respondents as a whole were thinking of in patient services. It is likely that the sick person, in cases where not advised by a doctor, would be taken to the emergency clinic and thence sent to the proper division within the hospital for treatment or observation.

Attitudes Towards and Use of Out Patient Departments

The final question in this general area dealt with an attempt to find out something about the use of and attitudes toward out-patient clinics in local hospitals. 82 respondents said that someone in the family had had some experience with one or more such clinics. It must be borne in mind that the use of clinics extends over a period of years and in some instances it is known that certain families attended irregularly and have not been to a hospital clinic for a long time. The high incidence of clinic usage indicates more than mere economic advantage. The character of service rendered, the convenience of location, and the attitudes of the staff help to explain the reasons why many of the families know about the clinics.

The type of hospital and clinic service is indicated in Table 12 (see following page). A wide variety of services has been used.

A total of 82 persons used the various clinics and paid at least 136 single visits which they said were satisfactory. In 21 instances dissatisfaction was recorded. Some of the reasons are included in such statements as:

"have to wait too long"
"they experiment on you"
"lady doctor gave me hell about something another doctor told me to do"
"they ask too many questions"

Dissatisfaction may be explained largely in terms of the lack of understanding on the part of the people of the necessary administrative detail, and that many people are for various reasons humiliated at having to go to a public clinic. Household duties or working schedules will not permit the leisure for an entire morning for a clinic. It is timely to reexamine the question of having more evening clinic service for family workers. This is not a new consideration by any means. Numerous places nave night clinics and other places formerly tried the experiment, but gave it up, largely for staff reasons.

Many families have but one member who has needed attention in some clinic, but there are other families which had more complicated situations. Some families used more than one clinic. See Table 13.

Table 12

USE OF HOSPITAL CLINICS BY FAMILY MEMBERS[1]

Hospitals \ Clinics	Asthma	Birth Control	Cardiac	Chest	Dental	Ear Nose Throat	Emergency	Eye	Gynecology	Genito-Urinary	Medical	Neurological	Obstetrics	Orthopedic	Payne Whitney	Pediatric	Physio-Therapy	Rheumatism	Skin	Surgical	Clinic Unident.	Total
Bellevue							1	1			1										2	5
City			1	1						1	1		1			1				1		7
Downtown																					1	1
Fifth Avenue																				1		1
Flower																				1		1
Gouverneur											1											1
Lenox Hill	1	1			1	1	2				1		2			2	2			1	2	16
Man. E E & T						4		4													1	9
Metropolitan					1		1				2									1	1	6
New York	2				2	4	20	4	2		15	2	2	5	1	14	2		5	8		88
N Y Eye & Ear								1														1
Neuro. Inst.												1										1
Polyclinic													1									1
Presbyterian											1									1		2
Roosevelt							1															1
Rup. and Crip.																		1				1
St. Vincent's							1															1
Vanderbilt											1	1										2
Totals	3	1	1	1	4	9	26	10	2	1	23	4	6	5	1	17	4	1	5	14	7	145

[1]Without reference to frequency or recency of use

Table 13

USE OF HOSPITAL CLINICS BY FAMILY GROUPS[1]

Incidence of Use	No. of Families
Used one clinic	45
Used two clinics	19
Used three clinics	10
Used more than three clinics	6
Total	80

[1] Without reference to recency of use

The evidence points toward the group having chronic disorders as those who make multiple use of hospital out-patient clinics.

Table 14 (next page) shows a rough relationship between use of hospital clinics and length of time lived in the block. It should not be inferred from the data presented that the respondent families did not change hospital clinic allegiance from time to time. All that can be said is that those who have lived 10 years or more in the block probably have remained "loyal" to the hospital clinic of original choice.

In Part I of this report, in connection with hospitalizing illness within a period of time among the families, some reasons are shown as to why certain hospitals are preferred. If it were possible, it would be in order to check the question of hospital choice or preference among a much larger segment of the population. Valuable light would be thrown upon the situation for the benefit of local hospital administrators.

Family Initiative in Serious Illness

The question was asked what the people would do if there was a shortage of doctors or nurses for a considerable period of time. About half of the families would attempt to care for the ill person at home and without assistance. The

Table 14

RELATION OF USE OF HOSPITAL CLINICS[1] TO LENGTH OF TIME LIVED IN BLOCK

Hospitals	Years in Block							Total
	Under 1	1-5	6-10	11-15	16-20	Over 20	Life	
Bellevue		1	1	1		2		5
City	3	1	1					5
Downtown		1						1
Fifth Avenue			1					1
Flower						1		1
Gouverneur		1						1
Lenox Hill	1	2	2	3	2	2		12
Manhattan Eye, Ear, and Throat		5	1	1	1	1		9
Metropolitan			3	1		1		5
Neurological Institute	1							1
New York	3	12	13	9	5	11	1	54
New York Eye and Ear Infirmary					1			1
Polyclinic			1					1
Presbyterian						2		2
Roosevelt				1				1
Ruptured and Crippled		1						1
St. Vincent's				1				1
Vanderbilt	1		1					2
								104

[1] Without reference to recency of use

remainder would "go for help". Table 15 gives some idea of what the families would do.

Table 15

THE KIND OF HELP PEOPLE WOULD SEEK IF DOCTORS AND NURSES WERE NOT AVAILABLE FOR A PERIOD OF TIME

Druggist	Friend	Hospital	Neighbor	Police	Other
8	4	19	6	18	6

Considerable confidence is placed upon the policeman who would be requested to call a city ambulance. In many cases, the family thinks of a city ambulance as a Bellevue ambulance. It is significant that not many would call upon a friend or neighbor, thus again stressing the shielding of a family health problem from outsiders and also emphasizing urban independence and aloofness. The high incidence of the choice of a hospital is to be noted - suggesting a lack of the fear of hospitals, and probably a respect for their ability to serve.

Annual Physical Examinations

Much hue and cry has been raised for some years about the desirability of having annual physical examinations. This question of an annual medical examination was put to the people, first as to the desirability and secondly as to their habit. On the first issue, 66 of the families said that they believed it to be a good thing to have annual physical examinations. When they were asked if the family members did have such checkups, a greater number replied in the negative.

Of those who professed to have annual checkups, the majority (12) went to some clinic. Only seven went to a private doctor. It was revealed that some of those attending the clinic were follow-up calls resulting from a previous illness, and that others go to clinics for an annual physical examination.

The Local Druggist

Some of the families place reliance upon the local druggists for advice in matters of sickness. Unfortunately, the question regarding the druggist was applied only to the last 45 families. Of these, 16 family representatives claimed

they had received advice from the druggists. However, many of the respondents could not recall the names and locations of their favorite druggists. Some four or five stores were identified while seven could not be identified. Examples of aid received were: advice not to have a gall bladder operation; medication for minor and major ailments, and recommendations for professional help. A hospital and/or a specific doctor were recommended for two pneumonia cases and a doctor was recommended for a parent. This portion of the investigation should at some time be carried further, either by some medical organization or by some adjunctive organization.

Conclusion

What has been said up to this point deals pretty largely with the curative, clinical approach. Nothing has been said about the preventive approach - a question which involves, in part at least, some consideration of the Department of Health clinics. This will be discussed in Part V of the report.

In summary, we may safely assume that the people have faith in private doctors and hospital clinics. They are, in the main, poor people, but some of them have enough foresight and initiative to do something about their health problems of a more serious nature. Whether or not they have more or less illness than persons in more fortunate circumstances has not been investigated in this survey.

PART III

Some Demographic Facts About the People in the Block

Attention has been given to the health of the people and the kind of aid they seek. In the milieu of all families are social and economic facts which help to explain illness. This section will present some consideration of the economic and demographic facts discovered during the course of the study. Relatively few analyses of the internal relationships of the data will be presented in this report.

Facts About Occupations and Income

The kind of work people do is indicative of many things in their lives. Occupation, amount of income, and levels of school experience are found to be closely related. Exactly what these relations are to problems of health is still a moot question, although studies have shown that low income folk generally have to spend proportionately more for health services than do those in the higher income brackets. Table 16 lists the occupations the people pursue.

Table 16

OCCUPATIONS REPRESENTED AMONG THE FAMILIES

Occupations	Sex		Totals	Occupations	Sex		Totals
	Male	Female			Male	Female	
Professional and semi-professional	2	2	4	Protective service	2		2
Clerical, sales and kindred	5	11	16	Service except Domestic and Protective	10	25	35
Craftsmen, Foremen and kindred	11		11	Laborers:			
				Manufacturing	8	2	10
				Non-Manufacturing	13		13
Operatives and kindred	28	5	33	Laborer	1		1
Domestic service		6	6				
Grand total number of employed: 131							

As might be expected, most of the household units have more than one person gainfully employed - see Table 17.

Table 17

GAINFULLY EMPLOYED
MEMBERS OF HOUSEHOLD UNITS*

Household Units By Size	Number of persons at work				House-hold Units	Persons at Work
	1	2	3	4		
1	2				2	2
2	13	6			19	25
3	7	9	1		17	28
4	8	11	3	1	23	43
5	5	4	1	1	11	20
6		2	1	1	4	11
8		1			1	2
Totals	35	33	6	3	77	131

* Does not include family members in armed services or those not living in the household unit who may give some financial assistance.

It would be interesting to know why the four member household unit seems to offer conditions that stimulate so many of its members to go out to work. It is almost too easy to ascribe the situation to war conditions alone. At first blush, one would be tempted to say that 131 people are at work supporting themselves and 178 others. Data at hand shows that 11 persons receive charitable aid, thus reducing to 167 the number of persons being directly supported by those employed.

The income of the people is always interesting to the investigator and is often a subject about which few people volunteer information. In most instances, the people cooperated very highly about giving such personal information. Table 18 (see following page) reveals the income range of these household units.

Table 18

AMOUNT OF WEEKLY INCOME BY FAMILY UNITS

Income Range[1]	No. of Families	Total	Income Range	No. of Families	Total
No income	11		$40-44.99	6	
Under $10	0		$45-49.99	9	
$10-14.99	2		$50-59.99	14	
$15-19.99	1		$60-69.99	3	
$20-24.99	2		$70-79.99	7	
$25-29.99	6		$80-89.99	3	
$30-34.99	5		$90-99.99	3	
$35-39.99	12		Over $100	2	
		39			86

[1]Total weekly income as of June 1944

The average household unit income was found to be $50.45 per week. This is considerably higher than anticipated. Preliminary investigation of rents paid within the last year in a similar block was found to be bi-modal at $20 and $25 per month. Assuming that rent usually represents 20% of the average budget, it is likely that these people are reaping the rewards of wartime pay. Several respondents told the interviewer that this is true, but that many people are staying on where they have lived partly because of the financial advantage to be obtained for the duration. A number of the families would not remain in the block if other things were equal.

The length of stay in the block negates the thesis that the people are highly mobile. As far as is known, there is no suitable evidence on a mass basis for incidence of annual mobility in Yorkville. Even if it were assumed that stability of residence is reached after a family were in a given house at least five years, we found a mobility of 32%. However, it is to be seriously doubted that a five year assumption is a valid one; consequently, we should reduce the suggested percentage

considerably. Of those families having lived in the block over 20 years, 4 have lived there 25 years, 5 for 30 years, and others for as many as 40 years. Table 19 indicates stability of residence.

Table 19

LENGTH OF TIME FAMILIES HAVE LIVED IN THE BLOCK

No. of Years	No. of Family Units
Under 1	9
1 5	21
6-10	18
11 15	11
16-20	11
Over 20	17
Life	4
Total	91

Reasons given aside from rentals that induce the people to stay where they were include the convenience of resources, such as hospitals, schools, churches, stores, and transportation. Another, and probably much more important reason, is ethnic group consciousness and the presence in the block of the T. J. Sokol, a Czech organization that serves the community for educational, social, and recreational purposes.

Family Composition and Age Groups

The ninety five families interviewed presented interesting family relationships. Table 20 portrays the general situation.

Table 20 COMPOSITION OF HOUSEHOLD UNITS BY FAMILY MAKE-UP

Household Units Comprising:	No. of Units	No. of Persons	No. of Children[1]	No. of Relatives	Broken Families[2]	Miscellaneous
1 person	7	7	0	0	0	7
2 persons	25	50	5	0	5	12
3 persons	23	69	24	2	3	0
4 persons	24	96	45	5	2	0
5 persons	11	55	28	7	2	0
6 persons	4	24	13	3	0	0
7 persons	1	8	5	1	0	0
Totals	95	309	120	18	12	19

[1] Regardless of age. Approximately 30% are adults.

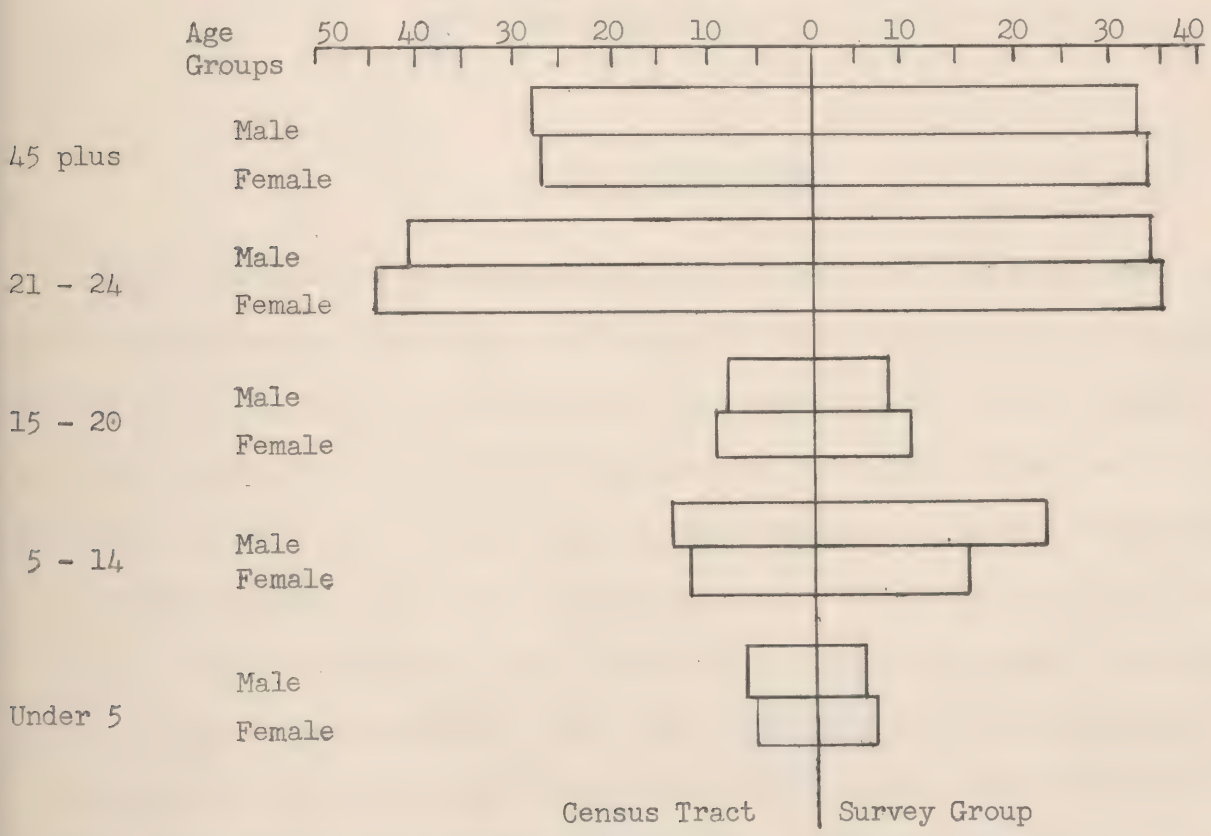
[2] Regardless of age of offspring living at home. The numbers indicate heads of family units.

The distribution is modal for the four member family unit but the average size of the household units is 3.04 members. When the household units which have children are considered separately, there are 1.37 children for each such household unit. As the size of the family unit increases, the number of adult relatives present increases - a fact which is probably explained by the need for having adult supervision for the children who have both parents at work or the widowed or divorced mother employed.

Chart 1 points up the comparison of ages between the group studied and the Census facts about the Census tract in which the surveyed families live. It will be noted that the closest agreement is that of the age group under 5. At least as far

Chart 1 AGE DISTRIBUTION OF THE INDIVIDUALS IN THE SURVEY AS COMPARED WITH THAT OF THE CENSUS TRACT IN WHICH THEY RESIDE AS REPORTED IN THE 1940 CENSUS

PERCENT



as these crude comparisons go, it might be argued that the facts discovered for the survey group, if really representative of the larger area of which they are a part, would hold true for all the people of the census tract concerned. However, age

group comparisons are not safe for too many inferences, since other variables such as ethnocentrism and associated factors are not revealed by them. Table 21 gives the composition of ages of the survey group.

Table 21 AGES OF INDIVIDUALS IN THE 95 FAMILIES[1]

Age Groups	Sex		Total
	Male	Female	
Under 5	8	11	19
5-14	31	25	56
15-20	9	14	23
21-44	47	57	104
45 plus	46	52	98
Total	141	159	300

[1]Age of nine persons not obtainable. The total number of persons in the survey was 309.

Ethnic Backgrounds

Ethnic matrimonial pairings are always interesting. Table 22 (next page) shows such choices together with certain demographic data. While there is considerable spread of nationalities, the predominant are American, Slovak, and Czech. As will be noted, there are in all, 19 different ethnic pairings[1], a fact which strongly suggests many different health patterns underlying the supposedly superimposed American pattern of health concepts and information. While these families live very near each other and represent only the major portion of the ethnic possibilities in the block, it is assumed that the ethnic pattern already discovered will hold true in the main for the other people in the block. One of the interesting facts shown in this table is the number of children involved in several of the ethnic

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[1] "Ethnic pairings" based upon group to which people belong, viz., the In nearly every case, citizenship is meant.

Table 22

ETHNIC PAIRINGS OF MARRIED COUPLES

Ethnic Pairings		Total Couples	Couples with No Children or Children Who Are Not at Home	Couples with Children at Home	Number of Children at Home [1]
Husband	Wife				
American	American	23	3	20	37
American	Czech	2	1	1	1
American	Italian	1		1	1
Czech	Czech	14	6	8	14
Czech	Slovak	1		1	2
German	German	2		2	6
German	Russian	1		1	2
Italian	American	1		1	3
Japanese	Czech	1		1	1
Polish	American	1		1	2
Russian	Russian	2	1	1	1
Scotch	Scotch	1	1		
Slovak	American	1		1	1
Slovak	Slovak	14	1	13	24
Ukranian	American	1		1	1
American	Irish-American	1		1	1
German	German-American	1	1		
Czech-American	Czech	1		1	2
Danish-American	Austro-American	1		1	3
	Totals	70	14	56	102

[1] Regardless of age. About 25% of this group are adults.

groupings, viz., the Czech-Czech group of fourteen couples with children at home have only fourteen children, whereas the Slovak-Slovak group account for 24 children among 14 couples. On the whole, the birth rate is crudely reflected in the fact that of the 56 couples with children at home, there are only 102 offspring, or 1.82 children per married couple maintaining an undisturbed "normal" family.

The fact that the major number of marital pairings had an "American" background led to analyzing the ethnic backgrounds of the grandparents of the heads of families under survey. The results were most interesting and provocative. Table 22 takes on a new significance after one studies Table 23 below.

Table 23

ETHNOCENTRISM OF GRANDPARENTS

Place of Birth	Grandparents				Totals
	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	
Austria	7	7	3	3	20
Czechoslovakia	57	57	48	46	208
Denmark			1	1	2
Finland			1		1
Germany	4	4	4	4	16
Greece	1	1	1	1	4
Hungary	8	8	4	4	24
Ireland	3	2	1	1	7
Italy	2	3	2	2	9
Japan			1	1	2
Poland	1	1	2	2	6
Russia	1	1			2
Schleswig-Holstein	1	1			2
Scotland	1	1	1	1	4
Slovakia	2	2	2	2	8
Ukraine	2	2	2	2	8
United States	3	3	6	7	19
Totals	93	93	79	77	342

There we have the data on all the household units visited, regardless of the number of children present or absent. Furthermore, no reservations are made for broken families. By all odds, the Czech group has the greatest prevalence in this array, a fact which does not stand out quite as sharply in Table 22 and many of the American families reported therein have Czech backgrounds. Data at hand shows that

many of the grandparents and some of their offspring were born in continental Europe, a fact which has an important bearing upon the ways in which many of the present inhabitants living in the block act with respect to their health problems. Austria, Hungary, Germany, and the United States have a significant representation among the grandparents' places of birth.

Education of Parents

One of the criteria by which the actions and beliefs of people may be judged is the amount and kind of education they possess. The following tables present some data on the educational experience of the households surveyed. For convenience, as well as other reasons, the educational experience of the household units is separated into two presentations, (see Tables 24 and 25).

Table 24 EDUCATIONAL EXPERIENCE OF HEAD OF HOUSEHOLD UNIT

Where Obtained	Less[1] than grammar school (-8)	Equivalent of grammar school (1-8)	High School grades[2]				College				Other (business secretarial, etc.)	Total
			9	10	11	12	1	2	3	4		
Unites States excluding NYC	2	2	1		1					1	1	8
New York City	10	16	1	1	1	2						31
Foreign	30	15		2	1	5					3	56
Totals	42	33	15				1				4	95

[1] - less than 8 grades
[2] - grades 9, 10, 11, 12 inclusive or 4 years beyond elementary (grammar) school

While many of the heads of the household units received their education in New York City, most got their education in Europe. The former group went further in school than the latter group. In many instances, where foreign training was the case, only four grades (or years) were completed. At this time, as far away as it is from the actual training that the people received in Europe, it is very

difficult and unfair to try to appraise it. When consideration of foreign training and learning a new language (English in this country) is made, one comes to the conclusion that all things considered, the heads of the household units have had a fair measure of success in earning a living and raising a family in the United States. Some thought was given to the notion that it is universally true that schools retain girls on their rolls longer than boys. Indications are that this assumption does not hold for these people as shown by a comparison of the two tables dealing with the present discussion.

Table 25

EDUCATIONAL EXPERIENCE OF WIVES*

Where Obtained	Less than 8th grade	Completion of grammar school	High School				College				Other	Total
			1	2	3	4	1	2	3	4		
United States excluding NYC	2	1		1								4
New York City	6	8	1	5	1	4					1	26
Foreign	26	10		1							1	38
Totals	34	19	13								2	68

* Does not include women who are heads of households. These are counted in the above table.

As far as the New York City trained group is concerned, the maxim of longer retention in school of girls over that of boys seemsto hold true, particularly as regards high school training.

Language Used by the Families

One would naturally suppose that numerous languages would be spoken in the various homes. Table 26 shows that while English is used in 65 percent of the situations, there are a number of other languages used which do not include any use of

English. One should not conclude from this statement, that some of those who say that they use a foreign language in the home do not have some knowledge of English. If it could be shown that the language pattern existing within this limited number of families holds true for the community in general, then we would have some basic data upon which to build an improved attack upon the health of the community. In passing, it is interesting to note that little or no up-to-date free health materials are readily available in the Czech or Slovak language.

Table 26

LANGUAGE SPOKEN IN HOMES

Language	No. of Household Units
Czech	17
English	50
German	1
Greek	1
Hungarian	2
Polish	1
Russian	3
Slovak	8
English and Czech	4
English and German	2
English and Hungarian	2
English and Slovak	3
English and Ukranian	1
Total	95

Finally, it remains to be discovered whether the ethnic groups are consciously preserving, to some degree at least, the language of their country of ethnic origins so that the culture may continue to exist. Here again is a fertile field of research for the ethnologist and the sociologist.

Religious Backgrounds

Table 27 reveals the religious groups with which the residents say they are identified. Since the question of religion is often a rather delicate one, little effort was made to discover whether the people in the block are active in church matters. A goodly number claimed affiliation, but many stated that they had been inactive for a long time. The majority claimed preference for the Catholic faith and among them are some Czechs. While no cross analyses have been made, it would be interesting to note the degree of relationship, if any, between health patterns and church groups for which affiliations is claimed. In any event, the suggestion of

Table 27

Religious Groups	Number
Atheist	1
Episcopalian	1
Greek Catholic	6
Lutheran	2
None	2
Presbyterian	5
Protestant	11
Roman Catholic	67
Total	95

the data is patent, e.g., that the Catholic church has a unique opportunity for co-operation in community health efforts. Anyone planning a concerted attack by the leaders of the community would do well to give an important place in the thinking and planning to the local clergy, and particularly to the Catholic clergy.

AGE-GRADE School Placement of Children

Table 28 (see following page) shows that there is no serious school retardation problem among the school aged children. Also, all of the children of school age are attending school. While only 46 elementary school children are involved, it is in order to ask such questions as - What kind of health concepts and information do they bring home? What is the kind and degree of conflict of those newer ideas with those held by the parents of the children? Do the parents pay any attention to the suggestions made by the school health staff? Some information on the last question may be seen in the following paragraphs.

What the Families Do About the Advice Given Them By School Health Personnel

The discussion here will be limited to attention given children in school by the school doctor and nurse through routine observation by them and by situations referred to them by the regular school staff. Some attention has already been given to the number of children attending school and the grades that are represented.

The question was put to the respondents regarding communications of any kind with the school staff (health or classroom) for health purposes. 23 respondents said that during the past year they had received some advice from the schools, and about an equal number said they had not. 6 said that the nurse had talked to them at the school, 3 said that the nurse had come to the home to talk about the children. In 7 instances, the children brought printed slips home, and the remainder indicated that they had talked with the classroom teacher. The respondents did not recall any instances where a conference between a school physician and a parent about any of the children was held. 15 of the parents said that they had carried out the recommendations given by the school health personnel. Table 29 illustrates the general situation as told by the respondents.

Table 28

NUMBER OF CHILDREN ATTENDING SCHOOL BY AGE,
SEX, AND PRESENT GRADE IN THE 95 HOUSEHOLD UNITS

Children Attending School			Elementary School								High School				Special	Total
Age	Sex	Kdg.	1	2	3	4	5	6	7	8	1	2	3	4		
5	B	2														2
	G	2														2
6	B	1	1													2
	G	1		1												2
7	B		1	3												4
				2	1											3
8	B			1	2	1										4
	G			1	2	2										5
9	B				1	1										2
	G					2	2									4
10	B						3									3
								1								1
11	B															0
	G							2								2
12	B								2	1						3
	G								1	1						2
13	B								2		1				1	4
	G								1							1
14	B								1	1	3	2				7
	G												1			1
15	B											3				3
	G											2				2
16	B												2	1		3
	G											1	1	2		4
17	B															0
	G												1			1
18	B												1			1
	G											1				1
Totals		6	2	8	6	6	5	3	7	3	4	9	6	3	1	69

Boys	38
Girls	31
Both sexes	69

Table 29

WHAT PARENTS DO ABOUT HEALTH ADVICE GIVEN
BY SCHOOL HEALTH PERSONNEL

Recommendations to Home		Conditions Corrected or Given Attention		No Suitable Attention Given	
No. of Cases	Health Condition Needing Attention	No. of Cases	Resources Used	No. of Cases	Reasons Given for Failure to Take Action
1	Diphtheria Immunization	1	Health Center[1]		
1	Heart Murmur	1	Rest in Country		
1	Medication (tonic)			1	Child disliked cod liver oil
2	Nervous System	1	Private Doctor	1	Parental inability to act upon advice
1	Nutrition	1	Home		
1	Physical Examination	1	Private Doctor		
2	Refraction	2	Health Center(1)		
8	Teeth	6	Health Center(4) Guggenheim (2)	2	Finances and indifference
4	Tonsillectomy			4	Advice of private doctor (3) Parental fear (1)
2	Throat Medication	2	Home		
23 (Total)		15 (Total)		8 (Total)	

[1] Health Center means Kips Bay-Yorkville Health Center

If it were true that the ratio as indicated in the table between those who do something about the advice given and those who do not holds for a much larger segment of the population, then it would seem that those in charge of school health programs and personnel have some very real problems. It has been the writer's experience to observe schools in numerous places and to study vicariously the operation of health programs in schools.

Conclusion

In conclusion, we can assert with a high degree of confidence that we are dealing with a low income group, the statistics about whom tell some interesting stories. These people have, on the whole, poor housing among other undesirable urban conditions. However, they are living their lives, as best they can, more or less accepting their lot, and yet possessing aspirations for their children so that they might escape the iron framework of low income, poor living conditions, the population density under which their forebears had to submit, and the attendant evils of disease.

PART IV

Evidence of the Desire of the People to Protect Their Health

Attention has already been called to the attitudes towards and use of certain channels of communication for health information. It will also be recalled that the people are conscious to some small degree of the possible relationship between health and environment. Attention will now be turned to some of the ways people think may help protect their families.

Insurance Coverage by Types

One way that the people can protect themselves and their families is by insurance. The respondents were asked if they had heard of Mayor La Guardia's plan for city wide health insurance for the people. Twenty one respondents had heard of the plan, but this signifies little, as they might know it by name only. However, they likely knew just enough about it to know that it is a constructive plan, largely engineered for their benefit. All 21 said that they would like to be enrolled in such a plan. The others were asked why they would not care to be included in such a scheme. In most instances the question remained unanswered. No attempt was made to probe into their state of mind on this point because the question was merely designed to determine sensitivity to the idea of health insurance in general. Next, they were asked if they had any kind of insurance at all. No attempt was made to identify the companies or to obtain information about the size of the policies. Seventy four families have some kind of protection and the remainder - 21, have none which partially reflects the economic status of the people. However, it must be remembered that some people do not believe in insurance, and others because of attitudes, actions, and opportunities in the past within the family, fail to take advantage of insurance protection. The three main kinds of insurance that they possess are industrial, endowment, and ordinary - about equally distributed. It was discovered by testing that such questions were necessary to set the stage for the real question - that about health insurance. Only one family said that they possessed a health insurance policy.

Fourteen families have hospitalization insurance, and five have group insurance. Several have accident and lodge policies. It seems evident, therefore, that health insurance is not widely used by the people as a means of protection and this is largely true for economic reasons. Judging by the amount of hospitalization and disabling illness at home during a period of one year, it is clear that much of the burden of loss of wages and professional payments would have been relieved had such a plan as proposed by the Mayor of New York been in existence for the low income folks included in this survey.

Desire For Attending Health Meetings

Insurance costs money, one way or another. But attendance at meetings may be even more expensive in the minds of some of the people - psychologically and socially speaking. Many attempts have been made, in ways overt and subtle, to get ethnic group folks to attend health meetings. The reason for failure to attend most frequently ascribed are lack of proper clothing, low educational level, language difficulty, lack of time, attitudes of husband, narcotization, and the curative health approach. But when the respondents were asked if they could be interested in personally attending health meetings, 40 replied in the affirmative. Next they were asked the time of the day and the most desirable location for the meetings. The two columns below show the degree of preference for various times during the day and the preferred sites for the meetings.

Time of Day	
Morning. . . .	7
Afternoon. . .	14
Evening. . . .	24

Preferred Sites	
Church	1
Do not know.	9
Health Center. . . .	16
Homes of mothers . .	1
Hospitals.	2
Lenox Hill Settlement	2
No preference. . . .	6
Some place near home	2
T.J. Sokol Club. . .	2

There are a few other factors in the picture that need consideration as far as meetings are concerned. For example, there are several rather well known medical representatives in private practice who are also ethnic group members. Again, there

is the expressed interest on the part of some 40 respondents as to the efficacy of health meetings. This interest must somehow be harnessed by giving the people the kinds of things they want and on their own terms. For example, according to the time preference for meetings, it is clear that both afternoon and evening meetings would be necessary. Assuming that the people interviewed are typical, then there is no argument that many others could be interested, providing that the sample would hold true for a larger population, and there is no reason why that assumption cannot be made. It is interesting to discover that the majority think that the Health Center would be a desirable place to meet. This suggests that some persons at least, regard the Center as not only a place for clinics but also a place where people should go to get health information.

What The People Think Would Help Them Maintain Good Health

The final question was an open-end catch all, to give the repondents an opportunity to say whatever they pleased. It was couched in language that would lead them to respond easily as to what they thought could be done to make it easier for their families to remain in a good health condition. The answers have been classified into broad categories and may be seen in the table below.

Table 30 - How People Would Maintain Good Health

Better Housing	11
Increased income	2
Information on how to keep well	3
Insurance	1
Meetings for health discussions	1
More recreation and time for relaxation.	5
Move to country	18
Private doctor	2
Special medical treatment	4
Summer vacation for children	3

The evidence is clear cut regarding the effect of the economic situation in the lives of the people. A perusal of the foregoing list indicates that in the main, the people feel that their health could be maintained in good fashion by being able to do things that money can buy. Only two of the items - that on more information and the other on health meetings are issues that are not directly economic and yet it can hardly be denied that economics plays some part in the latter, for reasons already discussed.

An attempt was made to ascertain some of the channels through which the people get their health ideas and information. The newspapers they read and the radio programs to which they listen are important. It was not anticipated that a fair number of families would own and consult medical books of a generalized nature. Several exhibited the compendium distributed by Dr. Morris Fishbein of the American Medical Association. It was interesting to learn that they had obtained the book through high pressure advertising in the local newspapers some time ago, wherein a discount was allowed for the presentation by the subscriber of the blank printed with the advertisement. The table below shows the subjects some of the people read about and where they find them.

Table 31

THE HEALTH READING INTERESTS OF
PEOPLE BY TYPE OF PRINTED COMMUNICATION

Subject Matter	Sources				Total
	Newspaper	Magazine	Book	Pamphlet	
Child Health			1		1
Cookery and Food	2	1		3	6
Dietetics	2	2	1		5
Diseases	2		2		4
Doctor's Column	11	5		1	17
First Aid		1			1
Health Articles	10	3	5		18
Home Nursing			2		2
Preventive Medicine	1		1		2
Question and Answer Column	1				1
TOTALS	29	12	12	4	57

It is quite evident that more people pay more regular attention to the health offerings of the printed sources than they do to those of the radio broadcasts. The table immediately following (see next page) indicates that talks by competent persons

do get some attention.

Table 32

THE HEALTH INFORMATION RADIO PROGRAMS
TO WHICH THE PEOPLE SAY THEY LISTEN

Programs or Listening Interests	Radio Stations						Total
	WNYC	WABC	WEAF	WJZ	WOR	Unident.	
Child Care			2	2		1	5
Diseases and Health Measures	2						2
Dr. Lindlahr					7		7
Doctors at War and at Work						1	1
Doctors on Health	3					3	6
Dietitian	1						1
Food			1	2	1		4
Nursing		1					1
Preventive Medicine						1	1
Rheumatism						1	1
Tuberculosis		1					1
TOTALS	6	2	3	4	8	7	30

In conclusion, it seems clear that much more needs to be done to arrive at valid answers to the whole question of desire to do something of a preventive nature for health maintenance.

PART V

Knowledge About and Use of the District Health Center

A casual trip through most of the health districts of New York usually reveals that the majority of the people do not know where their district health building is located, much less about what goes on there. As a matter of fact, if anyone of the groups could be said to be in better possession of the facts about such centers, that group would be the low income group. Yet even the low income group knows comparatively little about the location and services rendered in the city health centers. This section is concerned with the status enjoyed by the health center nearest the people in question.

These families live several short blocks due north of the health center and in the same number block. One would presume, therefore, since such a short distance is involved, since many of the people have been in the block for some time. (61% of the families have lived in the block for 5 years or longer) and since the health center building was opened in 1938, that many more people would know at least where the building is located. The fact is that 61 of the respondents said they knew of such a place, but only 51 (or 54%) of them could name the location or describe the building, while 6 named an adjoining street as the site. The other 34 of the respondents knew nothing about the building site. Of those who knew where the building is located, only 46 claimed to know anything about the services to be found there, or slightly over 50 percent of the respondents. This is not to be construed to mean that no one in the family knows the location, but it may be presumed that if the women of the household units do not know, then the other members of the family would not be likely to know. When they were asked to name the services, a variety of answers were given See Table 33 (next page).

Table 33

WHAT THE RESPONDENTS IN 95 FAMILIES KNOW ABOUT THE SERVICES IN THEIR DISTRICT HEALTH CENTER

Service	No. of Answers
Advice and Therapy	1
Chest Clinic	10
Child Health Certificate	1
Child Health Station	34
Communicable diseases	1
Dental Clinic	12
Eye Clinic	3
General	2
Home Nursing Course	1
Midwife Refresher Course	1
Physical examinations	1
Underpriveleged people	1
Venereal disease treatment	1

The Child Health Station

As will be noted from the preceding presentation, the people are most familiar with the preventive care supervision offered at the Child Health Station. Some of the information came to them by actual use of the Station, although a relatively few claimed ever having made use of it.[1] On the whole, their stock of information likely came from neighborhood conversations. Of the 24 children under six years of age in the families, apparently 13 of them are not under any kind of professional supervision. 3 are cared for by a local pediatric clinic and 5 by private doctors.

[1] In a previous study in this district of the selection factors by which people make use of health services, the Health Center Child Health Station seemed to be the chief identifying characteristic. Only a small percentage used the Child Health Station because it was "nearby and free"; most had had the Station recommended to them by some professionals. (Swackhamer, Gladys - Factors Motivating Selection and Use of Health and Medical Services, December, 1940, unpublished)

Three mothers said that they had formerly used the Station, but have now discontinued to do so. When asked the reasons for failure to use the Station, most people had nothing to say. The few who did make statements gave as reasons: "curative approach is sufficient",[2] "lack of time", and "fear that the staff would induce them to have tonsillectomies and the like for their children". In passing, it is interesting to note that 5 of the mothers do have a genuine preventive approach to the health supervision of their children.

The degree of usage of the station depends upon several factors, e.g., the presence of children under six years of age in the families; the choice of type of professional health supervision on the part of the parents; the willingness of the parents to use a public health resource; the convenience of that resource for them; and last but not least, their concept of health and particularly the preventive approach. Table 34 gives the ages and the number of children who would be eligible for supervision in the Child Health Station.

Table 34

THE NUMBER OF CHILDREN UNDER 6 YEARS OF AGE IN THE 95 FAMILIES

Age	Male	Female	Total
Under 2	3	4	7
2	1	1	2
3	2	3	5
4	2	3	5
5	2	3	5
Total	10	14	24

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[2] ibid 45 of 76 respondents "believed no further need". In many instances, mothers stopped bringing their children after the third birthday.

Empirical evidence alone as well as the experience of the Child Health Station staff is sufficient to reveal that a majority of parents do not use that service for child health supervision. The respondents were polled on this point. Numerous child health resources are being used and have been used; but, as expected, a significant number of children do not come under any kind of professional help. Table 35 is interesting although its implications are sharply limited by the paucity of cases.

Table 35 AGE OF CHILDREN ELIGIBLE FOR HEALTH SUPERVISION IN THE CHILD HEALTH STATION BY PRESENT STATUS AND TYPE OF SUPERVISION

Age	Under no Supervision	Active Supervision by Types			Total	Resources Used but Discontinued		Total
		Private Doctor	Health Center	Hospitals		Health Center	Hospitals	
Under 2	4	1	2		7			
2			1		1		1	1
3	1	1	2		4	1		1
4	1	1	2	1	5			
5	1	2			3	1	1	2
Totals	7	5	7	1	20	2	2	4

It was thought that birth sequence of the children might have something to do with the behaviour of the parents regarding child health supervision but apparently that phenomenon has no bearing on the situation as far as these families are concerned. See Table 36.

Table 36 BIRTH SEQUENCE OF CHILDREN UNDER SIX YEARS OF AGE WITH REFERENCE TO USE OF PROFESSIONAL CHILD HEALTH SUPERVISION

Birth Sequence	No. of Children	Under Present Care	Were Under Care	Under no Care[1]
1	11	5	2	4
2	9	5	2	2
3	3	3		
5	1			1
Total	24	13	4	7

[1]Total of 11 under no present care includes 4 who were under care but were discontinued.

Perhaps a much larger sample would be more revealing as regards this point.

Sometimes demographic factors reveal solutions but such does not seem to be the case with these families. See Table 37.

Table 37

HEALTH SUPERVISION STATUS OF CHILDREN UNDER 6 YEARS OF AGE TOGETHER WITH CERTAIN DEMOGRAPHIC FACTORS

Case	No. of Child.	Ethnic[1] B'kg'r'd	Weekly Income	Av. Ed. of Parents[2]	Time in Block	Number of Children Under Care			Under no Care[3]
						Priv.Dr.	C.H.S.	Other	
A	1	US -Ire.	$72	7	7 yrs				1
B	1	US - US	85	10	Life	1			
C	2	US - US	44	10	-	2			
D	1	US - US	33	10	29				1
E	2	US - US	38	8	3		2		
F	1	CS - CS	70	9½	23		1		
G	1	Sl - Sl	80	4	1	1			
H	1	Sl - Sl	38	5	-		1		
I	2	CS - CS	65	8	16				2
J	1	US - US	25	6	27				1
K	2	US - US	43	9½	4½		1		1
L	1	US - US	44	7½	18			1	
M	2	It - It	55	-	3				2
N	1	Uk - Uk	42	5	2		1		
O	2	US - US	100	9½	5 wks		1		1
P	1	CS - CS	46	9½	4				1
Q	1	US - It	50	9	1½	1			
R	1	US - US	25	10	2 mos				1
	24					5	7	1	11

Symbols: US-United States, CS-Czecho Slovakia, Sl-Slovakia, Ire-Ireland, It-Italy, Uk-Ukraine

[1] First symbol applies to father and second symbol to mother

[2] Mean of years of school completed by both parents

[3] Professional care

Six of the families where children are not under care have lived in the neighborhood less than five years. This condition may have something to do with the situation perhaps because the Health Center and its services are so little known.

Income does not seem to be a factor in the situation in families having no professional health supervision for their children. Only two families have as little as $25.00 per week income. The others have incomes that in some instances reach as high as $100.00 per week. The war situation is reflected in the higher incomes.

A check was run on the ethnic backgrounds of the parents whose young children do not have any professional health supervision. No one ethnic group stood out, very likely because of the paucity of cases. It should be remembered, however, that all ethnic groups have some factors in common, an important one being that they have for generations been used to having medical care only in severe cases of illness.

A lengthy discussion of ways and means to get an optimum number of people to use the Child Health Station is hardly the province of this report. It may be that the Child Health Station records should be studied so that more light would be thrown on the ethnic patterns involved. More research should be done in the community, perhaps on a basis of a carefully drawn stratified sample so that evidence of a continuing nature might be accumulated along the lines of degree and type of professional child health supervisory service used by the people of the community. Since the facts show that a great many families do not resort to such services some pattern of procedure acceptable to public and private resources needs to be carried further than is now the case. Many professionals claim that too few children come under any kind of professional health supervision.

The Other Clinical Services at the Health Center

Reference to Table 30 in this section shows that other clinical services are somewhat known - the chest clinic, the dental clinic and the eye clinic. When the people were asked if any of the family members had ever used the services mentioned, eight replied that the chest clinic had been used and eight had used the dental clinic. Three families had used the eye clinic, a service for children. In passing, it should be recalled that the incidence of tuberculosis in the general population would limit the number needing the chest clinic service. Furthermore, a social taboo concerning tuberculosis still exists to some degree - in fact, two respondents failed to mention the existence of some tuberculosis in their families. The dental clinic is limited largely to the care of the teeth of the elementary school children. Added to the situation is the nearness in the locality of a large

philanthropically supported public dental clinic for children Since the care of teeth has been greatly neglected by the people in past generations, one could not expect to find wide-spread preventive dental initiative on the part of the people

Satisfaction With the Way Things are Done at the Health Center

Twenty seven respondents said they were completely satisfied with the services rendered at the Health Center. Three were partially satisfied and four not at all satisfied. Misunderstanding, preconceived notions of procedures, lack of appreciation of administrative necessities, fear of contagion, long waits, and staff personalities are the chief reasons for dissatisfaction. It is in order to suggest that a larger study of this point be made to determine the opinions and attitudes of the people, since this survey included so few persons in a position to evaluate adequately the Health Center services.

A few of the respondents made mention of some of the newer adjunctive services of an educational nature recently offered at the Health Center, through the efforts of the District Health Committee. Information on nutrition, Red Cross classes, and the Food Tasting Party were mentioned. Even though only a few people had some knowledge of or experience with these services, it is in order to suggest that through such activities and others like them designed to attract the people of the community, will further inroads be made upon the health-services-available consciousness of the people.

It was thought that some of the people might have done some previous thinking about their municipal services and health in particular, hence an opportunity was extended to them to give their opinions about the things they thought the Health Center should be doing. While not very many had done much thinking about the extensions of service that might be offered, some felt that the Health Center should give medical care, largely for sick children.

Visits by Nurses, Social Workers, and Others

One of the excellent ways that the Health Center and its services are interpreted is through the nursing staffs - the school nurses and the members of tne Visiting Nurse Service of New York City. The respondents were asked if any nurse had been to see them during the year closing in June 1944. Thirteen families had had the benefit of a visit by a nurse. Six of the cases had been handled by the Visiting Nurse Service, and in seven others, school nurses had called at the homes. Eight respondents said that they were well satisfied with the services rendered, and two were dissatisfied. Apparently, the bedside nursing service is more appreciated than educational nursing service. Where follow-ups were done regarding treatment recommended by the school physicians, the degree of appreciation was not as favorable as in the case of bedside nursing.

According to the remarks made by the respondents, very few professionals of any kind of adjunctive services visited them during the year. Pension fund visitors called at four of the households, and a representative of the Children's Court went to visit one household. While it is somewhat surprising that none of the families reported any relationships with social workers, it is likely that some memories are poor.

On the whole, the acquaintanceship of the people with the Health Center is quite low. It is not known just what an optimum incidence of use should be, but the professional opinion is abroad that the Health Center is a potent health oasis that is passed by much more frequently than it is entered.

PART VI

Findings

Evidence that many families have not taken advantage of opportunities easily within their geographical and economic reach.

1. A significant number of adults have health problems largely of a chronic nature, but no one is helping them.
2. Considerable need for dental care for adults is indicated.
3. Acute respiratory diseases of a non-tubercular nature are of relatively high incidence among the people.
4. Some way of recognizing the need for social guidance is indicated for health workers inasmuch as no family reported a visit by a person trained to do such counselling, and some families were in the midst of acute social crises in which illness of one member played a primary part.
5. The need for a medical social worker as a member of the Health Center staff is indicated. Such a person should work out a pattern of practices so that she would give an optimum degree of service to the public, using both curative and preventive approaches. Families which are in need of help but who have not asked for it could make use of such a service. It seems quite clear that a definite segment of the population not now being reached would be helped.
6. There is a definite need for aiding the people to become better acquainted than they now are with health insurance coverage.

Nature of selectivity factors - Disparity between standards and practices.

1. Some of the health problems are cleared through the local druggists.
2. A need is present to demonstrate in some manner that increased real wages is not the total answer to improved health. Although many families are spending more than they ever did before for medical care, very

few adults have any regular medical supervision, and they receive no periodical health examinations except when their places of employment provide them, which is not frequent, being generally limited to heavy industry.

Further light on family health practices, beliefs and leadership as a basis for adjustment of services to actual need.

1. According to the expressed statement of the people, there is a definite need for meetings, providing informal talks by doctors and health experts in simple language, and allowing time for questions and answers. These people as a whole have a great respect for medical science and a real desire to inform themselves, but the gap between the knowledge of the physician and that of the people is so great that it can be overcome only by meeting the people at their level and helping them to integrate new ideas with old associations. The meetings should have for their subject matter such health phases as general health, degenerative diseases, child care, and food and nutrition. Serious consideration should be given to having some of the meetings in the languages used by the ethnic groups, since many of the mothers of families are not sure enough of their English to always get the point of and to share in the discussions. The desire to have literature in the languages of the ethnic groups was apparent. There was no evidence of a reading pattern or of more than casual listening to radio health programs.
2. The mothers of the families seem to bear the brunt of the illness load and hence are the group in greatest need.
3. Because of the loyalties of the people, together with the penchant of some of them to shop around, there is a need for some kind of medical record reference center.
4. A need for evening services in local out-patient departments is indicated.

5. A need for more educational nursing is indicated, with or without reference to the school relationships in existence.

6. The people expressed the need for health examinations, and for more liberal terms in the hospital and medical care plans of the insurance policies which a number were carrying at their plants.

7. Some evidence exists which points to the presence of psychosomatic problems among the adults, but it is difficult to discern at one visit what the degree of need may be.

8. Group Organizations (ethnic) apparently do not devote much or any of their time during the year to health discussions.

Child Care

1. Not all of the children under six years of age are under some form of professional health supervision. The Child Health Station at the local Health Center has a low incidence of usage by the people. None of the parents were receiving mental hygiene instruction in problems with the their children, though a few expressed a wish for it and many showed a need for it.

2. A conflict exists between some of the decisions given by the school physicians and those given by the private family physicians. Parents seem inclined to seek private physicians to obtain a reversal of decisions by school physicians. They also concede to their children's fear of dental care by sending them only intermittently to private dentists and accepting the children's fantastic tales about the dentist drilling holes in sound teeth at an excellent local dental service provided free to school children. The fact that this service refused to admit mothers during treatment may contribute to the situation.

3. A small portion of the mothers are interested in mental hygiene, but it is difficult to say that there is any real understanding of what

mental hygiene has to offer in establishing desirable habits and avoiding psychomatic ailments among children.

THE APPENDIX

Questionnaire For Interviewing Families Regarding Knowledge About And Use Of Health Resources, Inventory Of Health Problems, Channels Of Health Information And Other Factors

Developed By

Kips Bay-Yorkville District Health Committee

and

Department of Public Health and Preventive Medicine

Cornell University Medical College

June 1944

Date_____ GENERAL IDENTIFICATION INFORMATION Case No. _____

Address_____ Apt.No._____ No. in Family_____ Time in Block _____

Family Name_____ Chief Language Spoken in Home _____

Husband's First Name _____ Ethnic Group _____ Place of Birth _____

Wife's First Name _____ Ethnic Group _____ Place of Birth _____

Place of Birth-Husband's Parents: Mother _____ Father _____

Place of Birth- Wife's Parents: Mother _____ Father _____

Household* Names	Age	Education		Employment Status			Not Employed
		Where	Grade	Occupation	Industry	Process	
1							
2							
3							
4							
5							
6							
7							
8							
9.							
10							

*Interviewer should indicate relationship to primary family group where necessary

Income

___ A. No income*
___ B. Under $10
___ C. $10 to $14.99
___ D. $15 to $19.99
___ E. $20 to $29.99
___ F. $30 to $34.99
___ G. $35 to $39.99
___ H. $40 to $44.99
___ I. $45 to $49.99
___ J. $50 to $59.99
___ K. $60 to $69.99
___ L. $70 to $79.99
___ M. $80 to $89.99
___ N. $90 to $99.99
___ O. Over $100

Contributions to Family Income:

Member	Amount Contributed Weekly	Source	*Special
1. _____	_____	_____	_____
2. _____	_____	_____	_____

*Indicate relief, pension, church, military service person, etc.

Miscellaneous

Religion _____ Church _____ Time lived in Yorkville _____

Interpreter Used for Interview Yes ( ) No ( ) Name of Interpreter _____

General Appearance of Home:

Superior ( ) Good ( ) Fair ( ) Low ( ) Filthy ( ) Telephone in Apt. Yes ( ) No( )

Signature of Interviewer _____

I - HEALTH INVENTORY

A - What People Think is Best to do in Times of Illness

1. IF SOMEBODY IN YOUR FAMILY GOT REAL SICK ALL OF A SUDDEN, WHAT WOULD YOU DO?

a. Call a doctor ☐
b. Call an ambulance ☐
c. Take the sick person to a hospital ☐
d. Try to care for the sick person at home without help ☐
e. Wait awhile to see what happens ☐
f. Other _____

1 (a) HOW DO YOU KNOW WHEN A PERSON IS SICK ENOUGH FOR YOU TO CALL A DOCTOR OR TAKE HIM (HER) TO THE HOSPITAL?

_____

_____

1 (b) IF YOU THOUGHT THE PERSON SICK ENOUGH TO GO TO THE HOSPITAL, WHERE WOULD YOU TAKE HIM?

_____

1 (c) IF SOMEONE GOT REAL SICK AND YOU COULD NOT GET A DOCTOR OR A NURSE FOR A LONG TIME, WOULD YOU TAKE CARE OF THE SICK ONE ALL BY YOURSELF OR WOULD YOU GET SOMEBODY TO HELP YOU (TELL YOU WHAT TO DO)?

MYSELF ☐
GET HELP ☐

1 (d) IF GET HELP, ask: WHERE WOULD YOU GET HELP?

a. Friend ☐
b. Neighbor ☐
c. Druggist ☐
d. Hospital ☐
e. Police ☐
f. Other _____

1 (e) DO YOU EVER GET ADVICE ON HEALTH MATTERS FROM THE DRUGGIST?

YES ☐
NO ☐

1 (e)-1 If YES, ask: WOULD YOU MIND TELLING ME WHAT DRUGSTORE YOU GO TO FOR HELP OR ADVICE?

_____
Drugstore

1 (f) WHAT KIND OF HELP HAS YOUR DRUGGIST GIVEN YOU?

Comment:

B - Type of Professional Help Preffered

DO YOU THINK IT DOES ANY GOOD TO HAVE A THOROUGH CHECK UP BY A DOCTOR ONCE A YEAR?

YES ☐
NO ☐

Comment _____

_____

2a DO YOU HAVE YOURSELF AND YOUR FAMILY EXAMINED REGULARLY (ONCE A YEAR)?

YES ☐
NO ☐

Comment: _____

_____

If YES, ask: WHO DOES IT?

Clinic _____ (Name) Private Doctor ☐

2b DO YOU HAVE A FAMILY DOCTOR?

YES ☐
NO ☐

2c If YES, ask: DO YOU CALL HIM MOST OF THE TIME WHEN SOMEONE IN YOUR FAMILY IS SICK

YES ☐
NO ☐

2d If YES, ask: IS HE A SPECIALIST? ☐

IS HE A GENERAL PRACTITIONER? ☐

2e If YES, say: IT WOULD HELP US TO KNOW IF YOU HAVE BEEN SATISFIED WITH THE THINGS THE DOCTOR DID TO HELP THE SICK PERSON GET WELL. WERE YOU SATISFIED?

YES ☐
NO ☐

Comments:

2f WOULD YOU MIND TELLING ME WHERE HIS OFFICE IS?

Address _____ Name _____ (If volunteered)

2g HOW DID YOU LEARN ABOUT YOUR DOCTOR?

_____

2h WHEN WAS YOUR DOCTOR HERE LAST?

Comment: _____

_____

3. HAS ANYONE IN YOUR FAMILY BEEN TO A HOSPITAL CLINIC?

YES ☐
NO ☐

3a If YES, ask: WHO? WHERE DID HE (SHE) GO?

Family Member	Hospital	Clinic(s)	Approx. Date	Comment*

*Interviewer must include brief symbolic statement showing satisfaction or dissatisfaction with each clinic. Where necessary, use opposite sheet for reasons for dissatisfaction.

C - Present Illness

4. DOES ANYONE IN YOUR FAMILY HAVE SOMETHING WRONG WITH HIM NOW? YES ☐ NO ☐

4a If YES, ask: WHO IS IT? WHO IS TAKING CARE OF HIM (THEM)?

Family Member	Priv. Dr.	Health Center (clinic)	Hospital (name)	In-P	Out-P	At Home	Elsewhere (name)	No Care

4b WHAT DID THE DOCTOR SAY IS WRONG WITH HIM (THEM)?*

Condition:	Family Member	How Long?	Family Member	How Long?	Family Member	How Long?
Asthma						
Bronchitis						
Deformity						
Ears						
Eyes						
Gall bladder						
Gonorrhea						
Heart						
Hypertension						
Kidney						
Malnutrition						
Mental						
Nerves						
Obesity						
Syphilis						
Teeth						
Thyroid						
Tonsils						
Tuberculosis						
Upper Resp. Infection						
Varicose Veins						
Other						
Other						

*Interviewer should use opposite page to write respondent's vernacular description rather than attempt to translate information to a diagnosis in all cases where the slightest confusion exists.

Comments: _____

4c FOR CHRONIC CASES ONLY:

Family Member	Condition	C.A.	P.A.	N.A.	W.R.	W.P.	N.W.	P.V.A.

abbrev: C.A. - completely ambulatory
P.A. - partially "
N.A. - non "
W.R. - working regularly
W.P. - working part time
N.W. - not working
P.V.A. - performs usual activities

4d FOR CASES NOT UNDER CARE NOW:

Say: YOU TOLD ME THAT _____ IS NOT WELL NOW AND HAS NOT SEEN THE DOCTOR OR BEEN TO A CLINIC. WHAT DO YOU THINK IS WRONG WITH HIM (THEM)?

Family Member	Condition	How long?	Performing Usual Activities?

5. HAVE YOU LET ANY HEALTH CONDITION IN THE FAMILY RUN ON BECAUSE OF LACK OF MONEY? YES ☐ NO ☐

5a If YES, ask: WHO? WHAT IS THE TROUBLE:

Family Member	Condition

6. IF YOU HAD MORE MONEY TO SPEND TO GET YOUR HUSBAND (WIFE) AND CHILDREN IN THE BEST SHAPE, WHAT WOULD YOU HAVE FIXED UP FOR THEM?

1. Family member _____ Fix _____

2. Family member _____ Fix _____

3. Family member _____ Fix _____

4. Family member _____ Fix _____

D - Illness Within the Past Year and How It Was Cared For

7. HAS ANYONE IN YOUR FAMILY BEEN IN THE HOSPITAL OVER NIGHT OR LONGER WITHIN THE PAST YEAR? YES ☐ NO ☐

7a If YES, ask: WHO? WHAT HOSPITAL? WHAT WAS WRONG?

Family Member	Hospital	Nature of Illness	Satisfaction*

*Reasons for or against complete satisfaction

8. WHICH HOSPITAL DOES YOUR FAMILY LIKE BEST? _____

WHY? _____

9. HAS ANYONE IN YOUR FAMILY BEEN SICK IN BED AT HOME FOR A WEEK DURING THE LAST YEAR? YES ☐ NO ☐

9a If YES, ask: WHO? WHAT WAS WRONG?

Family Member	Nature of Illness

9b If 9 is YES, ask: WHO TOOK CARE OF HIM (THEM)?

Family Member	Parents	Relative	Doctor	Nurse	Neighbor	Other

D - The School Doctor and Nurse

Say - We are trying to improve the ways the school doctor and nurse help you with your children. So we have a few questions we would like you to answer for us.

10. DO YOU HAVE ANY CHILDREN GOING TO SCHOOL NOW? YES ☐ NO ☐

10a If YES, ask: HAS THE SCHOOL DOCTOR OR NURSE TALKED TO YOU OR SENT HOME A REPORT ABOUT THE HEALTH OF ANY OF YOUR CHILDREN DURING THE LAST YEAR? (SEPT. 1943) YES ☐ NO ☐

Nurse talked to me at school ☐

Doctor talked to me at school ☐

Nurse came to see me ☐

Child brought slip home ☐

10b If YES, ask: WERE YOU ABLE TO DO ANY OF THE THINGS HE (SHE) TOLD YOU TO DO? YES ☐ NO ☐

10c WHAT DID HE (SHE) SAY YOU SHOULD DO FOR YOUR CHILDREN?

Child	Advice Given	Carried Out?	If not, why not?

II - DESIRE FOR HEALTH INFORMATION

11. DO YOU LISTEN TO PROGRAMS ON THE RADIO ABOUT HOW TO KEEP WELL? YES ☐ NO ☐ SOMETIMES ☐

11a If YES, or SOMETIMES, ask: WHAT HEALTH PROGRAMS DO YOU LIKE, AND OVER WHAT STATIONS DO THE PROGRAMS COME?

Programs: _____

Stations: _____ _____ _____ _____ _____

11b DO YOU EVER BUY ANY MEDICINES ADVERTISED ON THE RADIO? YES ☐ NO ☐

11b 1 If YES, ask: DO YOU HAPPEN TO REMEMBER THEIR NAMES?

_____ _____

_____ _____

12. DO YOU THINK IT DOES ANY GOOD TO READ THINGS ON HOW TO KEEP THE FAMILY WELL? YES ☐ NO ☐ NO OPINION ☐

12a If YES, ask: DO YOU HAVE A CHANCE TO READ THINGS ABOUT HOW TO KEEP THE FAMILY WELL? YES ☐ NO ☐

12 b If 12a is YES, ask: WHAT DO YOU READ? WHERE DO YOU FIND IT?

Subject Matter	Sources					
	News paper	Maga zine	Book	Pamph lets	Ads	Other

12c If 12 is YES, ask: WOULD YOU LIKE TO RECEIVE SOMETHING TO READ SO YOU CAN HELP TO KEEP THE FAMILY WELL? YES ☐ NO ☐

12d If 12c is YES, ask: WHAT KINDS OF SUBJECTS DO YOU WANT TO READ?

_____

_____

III - FAMILIARITY WITH AND USE OF THE HEALTH CENTER

13. DO YOU HAPPEN TO KNOW WHERE A HEALTH CENTER IS LOCATED? YES ☐ NO ☐

13a If YES, ask: WHAT STREET IS IT ON? _____

13b DO YOU HAPPEN TO KNOW ANYTHING ABOUT THE SERVICES OR HELP YOU CAN GET AT THE HEALTH CENTER? YES ☐ NO ☐

13c If YES, ask: WHAT DO THEY DO FOR THE PEOPLE WHO GO THERE?

_____

13d If District Health Center not identified, ask: DO YOU HAPPEN TO KNOW WHERE THE HEALTH CENTER RUN BY THE BOARD OF HEALTH IS LOCATED? YES ☐ NO ☐

13d 1 If YES, ask: WHAT STREET IS IT ON? _____

13d 2 If identified, ask: WHAT DO PEOPLE GO THERE FOR?

14. HAS ANY MEMBER OF YOUR FAMILY USED ANY OF THE SERVICES AT THE HEALTH CENTER? YES ☐ NO ☐

14a If YES, ask: WHO WAS IT? WHICH SERVICES WERE USED?

Services	Family member	About how long ago?
Eye clinic		
Dental clinic		
Chest clinic		
Child Health Station		

15. WERE YOU SATISFIED WITH THE WAY THEY RAN THINGS AT THE HEALTH CENTER?

COMPLETELY ☐
PARTIALLY ☐
NOT AT ALL ☐

15a If answer is less than completely, ask: WHAT WAS THE MATTER?

16. DO YOU HAVE ANY CHILDREN NOT YET 6 YEARS OLD?

YES ☐
NO ☐

16a If YES, ask: HAVE ALL OF THEM OVER 6 MONTHS AND UNDER 6 YEARS BEEN VACCINATED?

YES ☐
NO ☐

16b If NO, ask: WHO HAS NOT BEEN VACCINATED?

Name:

16c Reason:

17. HAVE ALL OF YOUR CHILDREN UNDER 6 AND OVER 9 MONTHS HAD INJECTIONS TO PROTECT THEM AGAINST DIPHTHERIA?

YES ☐
NO ☐

17a If NO, ask: WHO HAS NOT HAD THE INJECTIONS?

_____ _____ _____

17b If not all immunized, ask: IS THERE SOME REASON FOR NOT HAVING THE INJECTIONS FOR THE CHILDREN?

YES ☐
NO ☐

Comment:

NO OPINION ☐

18. DO YOU USE THE CHILD HEALTH STATION AT THE CITY HEALTH CENTER TO HELP KEEP THE CHILDREN WELL?

YES ☐
NO ☐

18a If YES, ask: WHAT DO YOU GO THERE FOR?

Thing to do ☐
Keep the baby well ☐
Baby isn't well ☐
Other _____ ☐
Specify

18b If NO, ask: IS IT BECAUSE YOU HAVE SOME REASON FOR NOT TAKING THE CHILDREN THERE?

YES ☐
NO ☐

Comment:

19. WHAT KINDS OF THINGS DO YOU THINK THE HEALTH CENTER SHOULD DO FOR PEOPLE THAT THEY DON'T DO NOW?

20. HAS ANY NURSE VISITED YOUR HOUSE IN THE LAST YEAR? YES ☐ NO ☐

20a If YES, ask: WAS SHE A BLUE NURSE (HENRY STREET)? ☐

LENOX HILL ☐

SCHOOL NURSE ☐

OTHER _____
Specify

20b If YES, ask: WHEN THE NURSE CAME, DID SHE GIVE THE KIND OF SERVICE AND ADVICE WHICH WAS HELPFUL TO THE FAMILY? YES ☐ NO ☐

20b 1 If YES, ask: HOW DID SHE HELP YOU?

20b 2 If NO, ask: WHAT WAS THE MATTER?

21. HAS ANYONE ELSE BEEN TO SEE YOU OR HELP YOU WITH FAMILY HEALTH PROBLEMS? YES ☐ NO ☐

Comment:

IV - HEALTH INSURANCE

22. DOES THE FAMILY OR ANY MEMBER HAVE INSURANCE NOW? YES ☐ NO ☐

22a If YES, ask: Industrial ☐ Source: (if volunteered)

Health ☐

Endowment ☐

Other _____

22b If HEALTH, ask: WHAT TYPE?

Group Health ☐ Lodge Insurance ☐

Hospitalization ☐ Union Insurance ☐

22c HAVE YOU HEARD ABOUT THE MAYOR'S PLAN OF HEALTH INSURANCE FOR THE PEOPLE OF NEW YORK CITY? YES ☐ NO ☐

22d If YES, ask: WOULD YOU LIKE TO BE INSURED IN SUCH A PLAN IF IT IS ACCEPTED? YES ☐ NO ☐

22e If YES, ask: WHY?

22f If NO, ask: WHY?

23. WOULD YOU BE PERSONALLY INTERESTED IN GETTING TOGETHER TO TALK ABOUT WAYS OF KEEPING YOUR FAMILY WELL? YES ☐ NO ☐ DON'T KNOW ☐

Comment:

23a If YES, ask: WHAT KINDS OF THINGS WOULD YOU LIKE TO TALK ABOUT?

23b WHERE DO YOU THINK IT WOULD BE BEST TO GET TOGETHER FOR SUCH TALKS?

23c WHAT TIME OF THE DAY DO YOU THINK MOST PEOPLE WOULD LIKE TO GET TOGETHER MORNING ☐ AFTERNOON ☐ NIGHT ☐

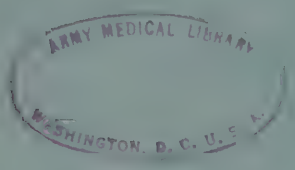
24. DO YOU THINK OF ANYTHING THAT WOULD MAKE IT EASIER FOR YOU TO KEEP YOUR FAMILY IN GOOD SHAPE?

25. SOCIAL EVALUATION OF FAMILY:
Include knowledge and use of resources, and names of those used (other than ones already mentioned), existence of social health problem and its nature, and name of any member who would make good leader in educational programs.

A SOCIAL SURVEY OF HEALTH AND ILLNESS IN URBAN FAMILIES

PAUL B. GILLEN

Kips Bay-Yorkville District Health Committee
and
The Department of Public Health and Preventive Medicine
Cornell University Medical College



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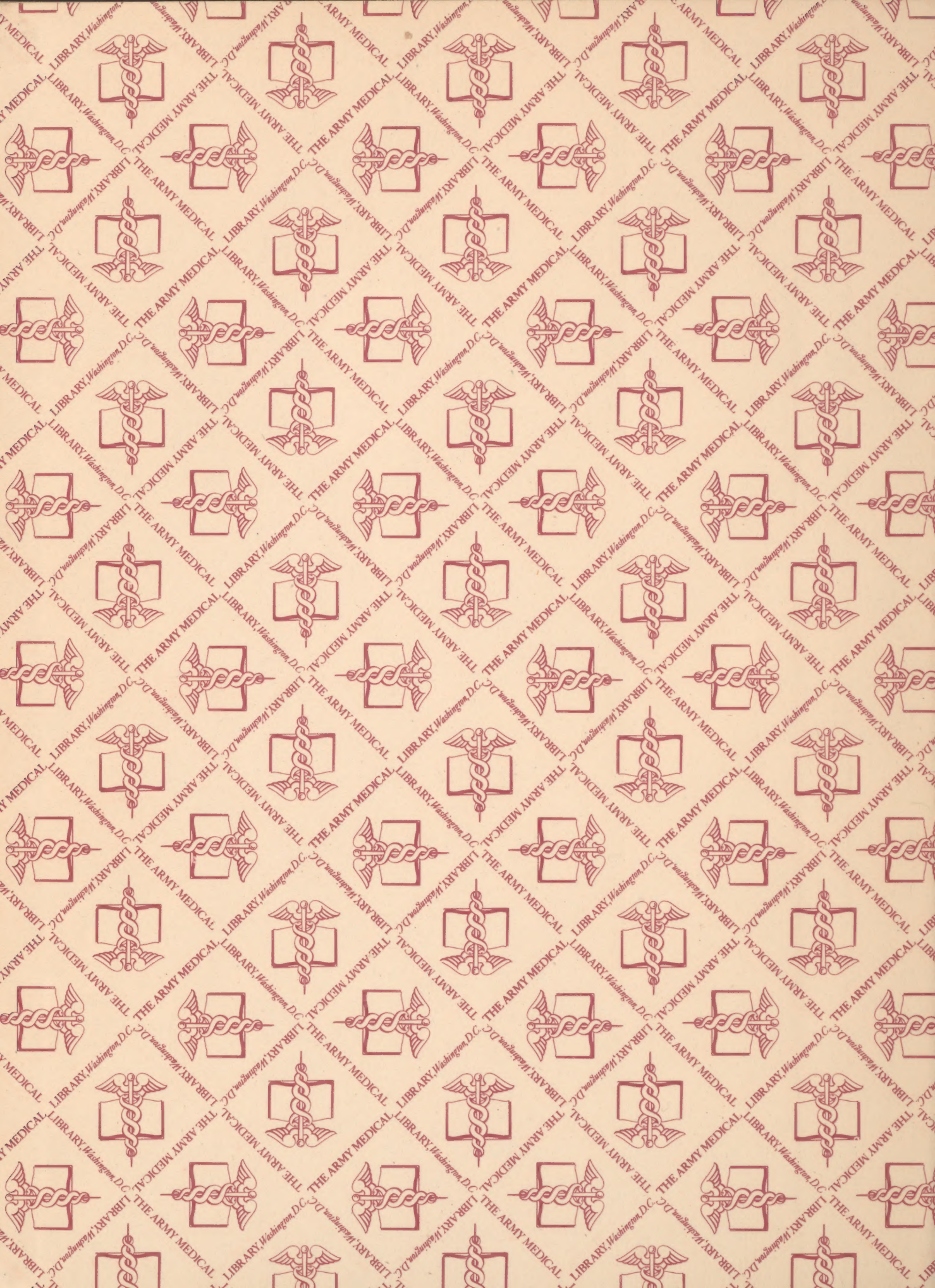
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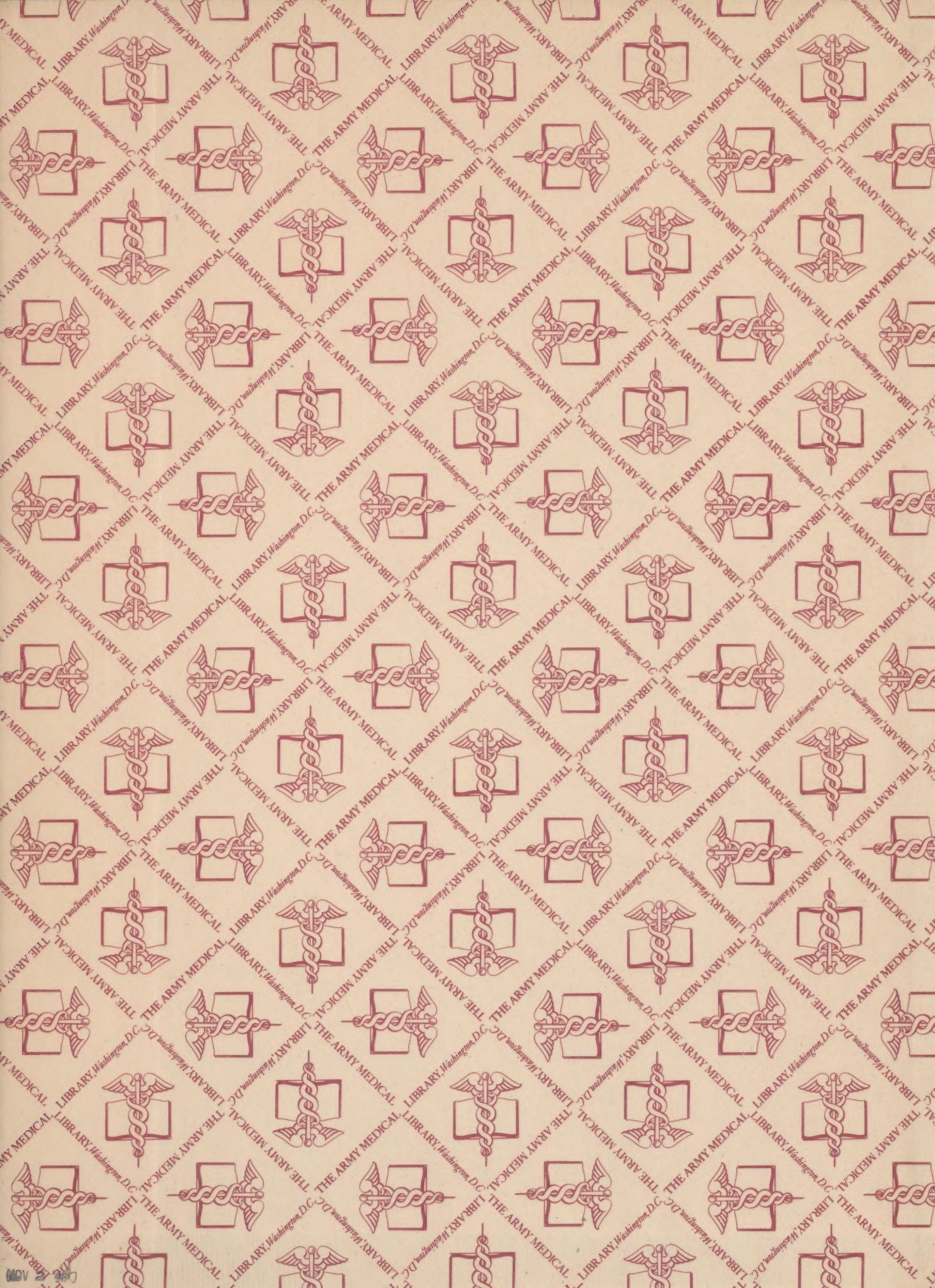
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